

## SERVICE CONTRACT

**THIS AGREEMENT** is made and entered into on \_\_\_\_\_, by the City of Pompano Beach (“City”) and AETNA Life Insurance Company, a Connecticut corporation authorized to do business in Florida (“Contractor”).

**WHEREAS**, City requires services which Contractor is capable of providing under the terms and conditions described herein; and

**WHEREAS**, Contractor is able and prepared to provide such services to City under the terms and conditions set forth herein, and

**WHEREAS**, Section 32.39 of the City’s Code of Ordinances Competitive Bidding states that before the General Services Director (also known as Purchasing Director) makes any purchase of, or contract for, supplies, materials, capital items, or insurance services in an amount less than seventy-five thousand dollars (\$75,000.00), the General Services Director or designee shall obtain a quote from at least one (1) responsible source of supply. In addition to the purchases described herewith, the General Services Director or designee shall have the authority to approve all other purchases in an amount less than two hundred thousand dollars (\$200,000.00), with the concurrence of the City Manager.

**NOW, THEREFORE**, in consideration of those mutual promises and the terms and conditions set forth hereafter, the parties agree as follows:

1. *Contract Documents.* This Agreement consists of the Solicitation RFP26-035 set forth in Exhibit “A,” the Contractor’s Response set forth in Exhibit “B,” the Insurance Requirements set forth in Exhibit “C,” and the fully insured and filed policy for the health plan (“Policy”) set forth in Exhibit “D,” all of which are attached hereto and made a part hereof; and all written modifications issued after execution of this Agreement.

In the event of any conflict or inconsistency between this Agreement and the provisions in the incorporated Exhibits, resolution shall be attained by giving precedence in the following order:

- (i) this Agreement,
- (ii) Exhibit “A”, Solicitation, addenda, Recommendation Tabulation and additional documentation.
- (iii) Exhibit “B”, Contractor’s Response.
- (iv) Exhibit “C”, Insurance Requirements.
- (v) Exhibit “D,” the Policy.

2. *Purpose.* The City, on behalf of its Human Resources Department desires to contract with Contractor to provide employee fully insured health benefits services upon the terms and conditions set forth herein.

3. *Scope of Work.* Contractor shall provide employee fully insured health benefits in accordance with Exhibits “A,” “B,” and “D” (collectively, the “Work”) attached hereto and made a part hereof. If the Work requires Contractor to provide materials to complete the Work within a specified time frame or in accordance with certain plans and specifications, these terms and conditions shall be set forth and included in Exhibits “A,” “B,” and “D” and Contractor agrees to provide said materials or Work in accordance therewith. Contractor and Contractor’s heirs, executors, administrators, successors and assigns, do hereby agree to full performance of all covenants contained herein on Contractor’s part.

4. *Term of Contract.* This Contract shall be for a term of five (5) years beginning with the date this Contract is fully executed by both parties.

5. *Renewal.* In the event City determines Contractor to be in full compliance with this Agreement and Contractor’s performance thereunder to be satisfactory, then City, with City Commission approval, shall have the option to renew this Agreement for two (2) additional one-year terms.

6. *Maximum Obligation.* City agrees to pay Contractor for performing the Work and providing the required insurance.

7. *Price Formula, Payment and Invoices.*

A. *Price Formula.* City agrees to pay Contractor for performance of the Work set forth in this Agreement as follows:

**Services shall be billed in accordance with the rate sheet provided in Exhibit “B.”**

B. *Payment.* All payments by City shall be made after the Work has been verified and completed. Unless disputed by City as provided herein, upon City’s receipt of a Proper Invoice as defined in § 218.72, Florida Statutes, as amended.

City shall timely provide Contractor written notification of any such disputed charge. Contractor shall provide clarification and a satisfactory explanation to City, along with revised copies of all such documents if inaccuracies or errors are discovered, within ten (10) days of receipt of City’s notice of the disputed amount.

Resolution of improper payment requests or invoices shall be in accordance with § 218.76, Florida Statutes, as amended.

C. *Invoices.* Contractor shall submit invoices to City on a monthly basis.

8. *Disputes.* Any factual disputes between City and the Contractor in regard to this Agreement shall be directed to the City Manager for the City, and such decision shall be final.

9. *Contract Administrators, Notices and Demands.*

A. *Contract Administrators.* During the term of this Agreement, the City's Contract Administrator shall be Lisa Sonogo, Human Resources Director. The Contractor's Contract Administrator shall be provided by Contractor upon commencement of services (or their authorized written designee) as further identified below.

B. *Notices and Demands.* A notice, demand, or other communication hereunder by either party to the other shall be effective if it is in writing and sent via registered or certified mail or other trackable delivery service, postage prepaid to the representatives named below or is addressed and delivered to such other authorized representative at the address as that party, from time to time may designate in writing and forward to the other.

**If to Contractor:** Renthia Jackson  
VP, Client Management– Aetna Public & Labor Sector  
151 Farmington Avenue  
Hartford, CT 06156  
Office: 9543751577  
Email: rxjackson@aetna.com

**If to City:** Lisa Sonogo  
Human Resources Director  
100 West Atlantic Blvd  
Pompano Beach, FL 33060  
Office: 954-786-5555  
Email: Lisa.Sonogo@copbfl.com

**With a copy to:** Director of Procurement & Contracts  
City of Pompano Beach  
Post Office Drawer 1300  
Pompano Beach, Florida 33061  
Tel: 954-786-4098  
Email: purchasing@copbfl.com

10. *Ownership of Documents and Information.* All information, data, reports, plans, procedures or other proprietary rights in all Work items, developed, prepared, assembled or compiled by Contractor as required for the Work hereunder, whether complete or unfinished, shall be owned by the City without restriction, reservation or limitation of their use and made available at any time and at no cost to City upon reasonable written request for its use and/or distribution as City deems appropriate provided City has compensated Contractor for said Work product. City's re-use of Contractor's Work product shall be at its sole discretion and risk if done without Contractor's written permission. Upon completion of all Work contemplated hereunder or termination of this Agreement, copies of all of the above data shall be promptly delivered to the City's Contract Administrator upon written request. The Contractor may not disclose, use, license or sell any work developed, created, or otherwise originated hereunder to any third party

whatsoever. The rights and obligations created under this Article shall survive the termination or expiration of this Agreement.

To the extent it exists and is necessary to perform the Work hereunder, City shall provide any information, data and reports in its possession to Contractor free of charge.

11. *Termination.*

A. *Termination for Breach or Default.* Breach or default of any of the covenants, duties, or terms of this Agreement shall be cause for termination, in whole or in part, of this Agreement. In the event of a breach or default, the defaulting party shall be given written notice in accordance with Article 9 herein which describes in reasonable detail the alleged breach or default and ten (10) calendar days to cure same. Failure to cure all such described defects within the required time period shall result in termination of this Contract with written notice to Contractor.

B. *Termination for Convenience.* City retains the right to terminate this Agreement for convenience upon ten (10) business days written notice to Contractor in accordance with Article 9 herein. Such Notice of Termination may include City's proposed Transition Plan and timeline for terminating the Work, requests for certain Work product documents and materials, and other provisions regarding winding down concerns and activities. City shall compensate Contractor for all authorized Work satisfactorily performed through the termination date under the payment terms set forth in Article 7 above and all Work product documents and materials shall be delivered to City within ten (10) business days from the Notice of Termination. If any Work hereunder is in progress but not completed as of the date of the termination, then upon City's written approval, this Agreement may be extended until said Work is completed and accepted by City.

12. *Force Majeure.* Neither party shall be obligated to perform any duty, requirement or obligation hereunder if such performance is prevented by fire, hurricane, earthquake, explosion, war, civil disorder, sabotage, accident, flood, acts of nature or by any reason of any other matter or condition beyond the control of either party which cannot be overcome by reasonable diligence and without unusual expense ("Force Majeure"). In no event shall economic hardship or lack of funds be considered an event of Force Majeure. If either party is unable to perform or delayed in their performance of any obligations hereunder by reason of any event of Force Majeure, such inability or delay shall be excused at any time during which compliance therewith is prevented by such event and during such period thereafter as may be reasonably necessary for either party to correct the adverse effect of such event of Force Majeure.

Contractor must follow all Federal, State, County, and City safety guidelines, including all CDC safety guidelines in effect during the term of this Agreement, including but not limited to social distancing, and personal protective equipment. Inability to provide the Work and follow any and all required safety guidelines applicable to the COVID-19 virus or other similar pandemic or emergency, or failure to follow such requirements, including but not limited to, social distancing, shall constitute grounds for immediate cancellation of this Agreement unilaterally by the City upon written notice, which may be provided via registered or certified mail or other trackable delivery service.

13. *Insurance.* Contractor shall maintain insurance in accordance with Exhibit “C” throughout the term of this Agreement. Contractor shall be responsible for ensuring all of its subcontractors providing services pursuant to this Agreement obtain and maintain liability insurance adequate to meet all indemnification requirements of Contractor as set forth herein.

14. *Indemnification.* Except as expressly provided herein, no liability shall attach to the City by reason of entering into this Agreement.

A. Contractor shall at all times indemnify, defend, save and hold harmless the City, its officers, officials, employees, volunteers and other authorized agents from and against any and all claims, demands, suit, damages, attorneys’ fees, fines, losses, penalties, defense costs or liabilities suffered by the City arising directly or indirectly from Contractor’s performance under this Contract, including but not limited to, any act, breach, omission, negligence, recklessness or misconduct of Contractor its subcontractors, service providers, and/or any of its agents, officers, or employees hereunder, including any inaccuracy in or breach of any of the representations, warranties or covenants made by the Contractor, its subcontractors, service providers its agents, officers and/or employees, in the performance of services of this Agreement. Contractor agrees to investigate, handle, respond to, provide defense for, and defend any such claims at its sole expense and to bear all other costs and expenses related thereto, even if the claim(s) is/are groundless, false or fraudulent. To the extent considered necessary by City, any sums due Contractor hereunder may be retained by City until all of City’s claims for indemnification hereunder have been settled or otherwise resolved, and any amount withheld shall not be subject to payment of interest by City.

B. Contractor acknowledges and agrees that City would not enter into this Agreement without Contractor’s indemnification of the City. The parties agree that one percent (1%) of the total compensation paid to Contractor hereunder shall constitute specific consideration to Contractor for the indemnification provided under this Article and these provisions shall survive expiration or early termination of this Agreement.

15. *Sovereign Immunity.* Nothing in this Agreement shall constitute a waiver by the City of its sovereign immunity limits as set forth in section 768.28, Florida Statutes. Nothing herein shall be construed as consent from either party to be sued by third parties.

16. *Non-Assignability and Subcontracting.*

A. *Non-Assignability.* This Agreement is not assignable and Contractor agrees it shall not assign or otherwise transfer any of its interests, rights or obligations hereunder, in whole or in part, to any other person or entity without City’s prior written consent which must be sought in writing not less than fifteen (15) days prior to the date of any proposed assignment. Any attempt by Contractor to assign or transfer any of its rights or obligations hereunder without first obtaining City’s written approval shall not be binding on City and, at City’s sole discretion, may result in City’s immediate termination of this Agreement whereby City shall be released of any of its obligations hereunder. In addition, this Agreement and the rights and obligations herein shall not be assignable or transferable by any process or proceeding in court, or by judgment, execution, proceedings in insolvency, bankruptcy or receivership. In the event of Contractor’s insolvency or bankruptcy, City may, at its option, terminate and cancel this Agreement without any notice of any

kind whatsoever, in which event all rights of Contractor hereunder shall immediately cease and terminate.

B. *Subcontracting.* Upon request, Contractor will provide City a list of subcontractors for whom a portion of services may include direct member contact of significant access to member data. For purposes of this Agreement, the term “Subcontractor” shall mean any persons or entities other than Contractor utilized by Contractor to provide any services pursuant to this Agreement. Contractor remains responsible for any and all contractual obligations hereunder and shall also be responsible to ensure that none of its proposed subcontractors are listed on the *Convicted Vendors List* referenced in accordance with the provisions of Article 28 below.

17. *Performance Under Law.* The Contractor, in the performance of duties under the Agreement, agrees to comply with all applicable local, state and/or federal laws and ordinances including, but not limited to, standards of licensing, conduct of business and those relating to criminal activity, and the Americans with Disabilities Act (ADA).

18. *Audit and Inspection Records.* The Contractor shall permit the authorized representatives of the City to inspect and audit all data and records of the Contractor, if any, for the sole purpose of determining compliance with the terms of the award of this Contract until the expiration of two (2) years after final payment under this Contract.

19. A. *Adherence to Law.* Both parties shall adhere to all applicable laws governing their relationship with their employees including, but not limited to, laws, rules, regulations and policies concerning worker’s compensation, unemployment compensation and minimum wage requirements.

B. *Conflict of Interest.* During the time period this Agreement is in effect, Contractor, its employees, subcontractors, and agents shall not engage in any conduct or activities that would constitute a conflict of interest, and shall otherwise avoid any appearance of such conflict of interest. Additionally, Contractor, its employees, subcontractors, and agents shall refrain from acting adverse to the City’s interest in promoting the goals and objectives of this Agreement. Any potential such conflict of interest must be reported to the City and may be waived only upon additional review and approval by the City Manager.

Furthermore, none of Contractor's employees, subcontractors, and agents shall, during the term of this Agreement, serve as an expert witness against City in any legal or administrative proceeding in which he, she, or Contractor is not a party, unless compelled by court process. Further, such persons shall not give sworn testimony or issue a report or writing, as an expression of his or her expert opinion, which is adverse or prejudicial to the interests of City in connection with any such pending or threatened legal or administrative proceeding unless compelled by court process. The limitations of this section shall not preclude Contractor or any persons in any way from representing themselves, including giving expert testimony in support thereof, in any action or in any administrative or legal proceeding.

The existence of any such conflict of interest, or evidence of non-compliance with the above paragraphs, may serve as grounds for termination of this Agreement pursuant to Paragraph 11, Termination.

20. *Independent Contractor.* The Contractor shall be deemed an independent Contractor for all purposes, and the employees of the Contractor or any of its contractors, subcontractors and the employees thereof, shall not in any manner be deemed to be employees of City. As such, the employees of the Contractor, its Contractors or subcontractors, shall not be subject to any withholding for tax, social security or other purposes by City, nor shall such Contractor, subcontractor or employee be entitled to sick leave, pension benefits, vacation, medical benefits, life insurance, workers or unemployment compensation or the like from City.

21. *Contractor Cooperation.* The Contractor recognizes that the performance of this Contract is essential to the provision of vital public services and the accomplishment of the stated goals and mission of City. Therefore, the Contractor shall be responsible to maintain a cooperative and good faith attitude in all relations with City and shall actively foster a public image of mutual benefit to both parties. The Contractor shall not make any statements or take any actions detrimental to this effort.

22. *Public Records.*

A. The City of Pompano Beach is a public agency subject to Chapter 119, Florida Statutes. The Contractor shall comply with Florida's Public Records Law, as amended. Specifically, the Contractor shall:

1. Keep and maintain public records required by the City in order to perform the service.

2. Upon request from the City's custodian of public records, provide the City with a copy of requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in Chapter 119, Florida Statutes or as otherwise provided by law.

3. Ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of the contract term and following completion of the contract if the Contractor does not transfer the records to the City.

4. Upon completion of the contract, transfer, at no cost to the City, all public records in possession of the Contractor, or keep and maintain public records required by the City to perform the service. If the Contractor transfers all public records to the City upon completion of the contract, the Contractor shall destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. If the Contractor keeps and maintains public records upon completion of the contract, the Contractor shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to the City, upon request from the City's custodian of public records in a format that is compatible with the information technology systems of the City.

B. Failure of the Contractor to provide the above-described public records to the City within a reasonable time may subject Contractor to penalties under 119.10, Florida Statutes, as amended.

## **PUBLIC RECORDS CUSTODIAN**

**IF THE CONTRACTOR HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO THE CONTRACTOR'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS CONTRACT, CONTACT THE CUSTODIAN OF PUBLIC RECORDS AT:**

### **CITY CLERK**

**100 W. Atlantic Blvd., Suite 253**

**Pompano Beach, Florida 33060**

**(954) 786-4611**

**[RecordsCustodian@copbfl.com](mailto:RecordsCustodian@copbfl.com)**

23. *Governing Law; Venue; Waiver of Jury Trial.* This Agreement shall be interpreted and construed in accordance with and governed by the laws of the State of Florida. The exclusive venue for any litigation arising from, related to, or in connection with this Agreement shall be in the Seventeenth Judicial Circuit in and for Broward County, Florida, or in the United States District Court for the Southern District of Florida, or United States Bankruptcy Court for the Southern District of Florida, as applicable. BY ENTERING INTO THIS AGREEMENT, THE PARTIES EXPRESSLY WAIVE ANY RIGHTS EITHER PARTY MAY HAVE TO A TRIAL BY JURY OF ANY CIVIL LITIGATION RELATED TO THIS AGREEMENT.

24. *Waiver and Modification.*

A. No waiver made by either party with respect to performance, manner, time, or any obligation of either party or any condition hereunder shall be considered a waiver of that party's rights with respect to the particular obligation or condition beyond those expressly waived in writing or a waiver of any other rights of the party making the waiver or any other obligations of the other party.

B. *No Waiver by Delay.* The City shall have the right to institute such actions or proceedings as it may deem desirable for effectuating the purposes of this Agreement provided that any delay by City in asserting its rights hereunder shall not operate as a waiver of such rights or limit them in any way. The intent of this provision is that City shall not be constrained to exercise such remedy at a time when it may still hope to otherwise resolve the problems created by the default or risk nor shall any waiver made by City with respect to any specific default by Contractor be considered a waiver of City's rights with respect to that default or any other default by Contractor.

C. Either party may request changes to modify certain provisions of this Agreement; however, unless otherwise provided for herein, any such changes must be contained in a written amendment executed by both parties with the same formality of this Agreement.

25. *No Contingent Fee.* Contractor warrants that other than a bona fide employee working solely for Contractor, Contractor has not employed or retained any person or entity, or paid or agreed to pay any person or entity, any fee, commission, gift or any other consideration to solicit or secure this Agreement or contingent upon or resulting from the award or making of this Agreement. In the event of Contractor's breach or violation of this provision, City shall have the right to terminate this Agreement without liability and, at City's sole discretion, to deduct from the Price Formula set forth in Article 7 or otherwise recover the full amount of such fee, commission, gift or other consideration.

26. *Attorneys' Fees and Costs.* In the event of any litigation involving the provisions of this Agreement, both parties agree that the prevailing party in such litigation shall be entitled to recover from the non-prevailing party reasonable attorney and paraprofessional fees as well as all out-of-pocket costs and expenses incurred thereby by the prevailing party in such litigation through all appellate levels.

27. *No Third-Party Beneficiaries.* Contractor and City agree that this Agreement and other agreements pertaining to Contractor's performance hereunder shall not create any obligation on Contractor or City's part to third parties. No person not a party to this Agreement shall be a third-party beneficiary or acquire any rights hereunder.

28. *Public Entity Crimes Act.* As of the full execution of this Agreement, Contractor certifies that in accordance with §287.133, Florida Statutes, it is not on the *Convicted Vendors List* maintained by the State of Florida, Department of General Services. If Contractor is subsequently listed on the *Convicted Vendors List* during the term of this Agreement, Contractor agrees it shall immediately provide City written notice of such designation in accordance with Article 9 above.

29. *Entire Agreement.* This document incorporates and includes all prior negotiations, correspondence, conversations, agreements or understandings applicable to the matters contained herein, and the parties agree that there are no commitments, agreements or understandings concerning the subject matter of this Agreement that are not contained in this document. Accordingly, it is agreed that no deviation from the terms hereof shall be predicated upon any prior representations or agreements, whether oral or written.

30. *Headings.* The headings or titles to Articles of this Agreement are not part of the Agreement and shall have no effect upon the construction or interpretation of any part of this Agreement.

31. *Counterparts.* This Agreement may be executed in one (1) or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one (1) and the same instrument. A photocopy, email or facsimile copy of this Agreement and any signatory hereon shall be considered for all purposes as original.

32. *Approvals.* Whenever CITY approval(s) shall be required for any action under this Agreement, said approval(s) shall not be unreasonably withheld.

33. *Absence of Conflicts of Interest.* Contractor represents that it presently has no interest and shall acquire no interest, either direct or indirect, which would conflict in any manner with their performance under this Agreement and that no person having any conflicting interest shall be employed or engaged by either party in its performance under this Agreement.

34. *Binding Effect.* The benefits and obligations imposed pursuant to this Agreement shall be binding and enforceable by and against the parties hereto.

35. *Employment Eligibility.* By entering into this Contract, the Contractor becomes obligated to comply with the provisions of Section 448.095, Fla. Stat., "Employment Eligibility." This includes but is not limited to utilization of the E-Verify System to verify the work authorization status of all newly hired employees, and requiring all subcontractors to provide an affidavit attesting that the subcontractor does not employ, contract with, or subcontract with, an unauthorized alien. Failure to comply will lead to termination of this Contract, or if a subcontractor knowingly violates the statute, the subcontract must be terminated immediately. Any challenge to termination under this provision must be filed in the Circuit or County Court no later than twenty (20) calendar days after the date of termination. If this Contract is terminated for a violation of the statute by the Contractor, the Contractor may not be awarded a public contract for a period of one (1) year after the date of termination.

36. *Scrutinized Companies.* By execution of this Agreement, in accordance with the requirements of F.S. 287.135 and F.S. 215.473, Contractor certifies that Contractor is not participating in a boycott of Israel. Contractor further certifies that Contractor is not on the Scrutinized Companies that Boycott Israel list, not on the Scrutinized Companies with Activities in Sudan List, and not on the Scrutinized Companies with Activities in Iran Terrorism Sectors List, nor has Contractor been engaged in business operations in Syria. Subject to limited exceptions provided in state law, the City will not contract for the provision of goods or services with any scrutinized company referred to above. In accordance with Section 287.135, Florida Statutes as amended, a company is ineligible to, and may not, bid on, submit a proposal for, or enter into or renew a contract with any agency or local government entity for goods or services of:

A. Any amount if, at the time of bidding on, submitting a proposal for, or entering into or renewing such contract, the company is on the Scrutinized Companies that Boycott Israel List, created pursuant to Section 215.4725, Florida Statutes, or is engaged in a boycott of Israel; or

B. One million dollars (\$1,000,000.00) or more if, at the time of bidding on, submitting a proposal for, or entering into or renewing such contract, the company:

1. Is on the Scrutinized Companies with Activities in Sudan List of the Scrutinized Companies with Activities in Iran Terrorism Sectors List, created pursuant to Section 215.473, Florida Statutes; or

2. Is engaged in business operations in Syria.

C. Submitting a false certification or being placed on a list created pursuant to Section 215.473, Florida Statutes relating to scrutinized active business operations in Iran after Contractor has submitted a certification, shall be deemed a material breach of contract. The City shall provide notice, in writing, to Contractor of the City's determination concerning the false certification. Contractor shall have five (5) days from receipt of notice to refute the false certification allegation. If such false certification is discovered during the active contract term, Contractor shall have ninety (90) days following receipt of the notice to respond in writing and demonstrate that the determination of false certification was made in error. If Contractor does not demonstrate that the City's determination of false certification was made in error then the City shall have the right to terminate the contract and seek civil remedies pursuant to Section 287.135, Florida Statutes, as amended from time to time.

37. *Affidavit of Compliance with Anti-Human Trafficking Laws.* In accordance with section 787.06 (13), Florida Statutes, the undersigned, on behalf of the entity listed below ("Entity"), hereby attests under penalty of perjury that:

A. Entity does not use coercion for labor or services as defined in Section 787.06, Florida Statutes, entitled "Human Trafficking".

38. *Affidavit of Compliance with Foreign Entity Laws.* The undersigned, on behalf of the entity listed below ("Entity"), hereby attests under penalty of perjury as follows:

A. Entity is not owned by the government of a foreign country of concern as defined in Section 287.138, Florida Statutes.

B. The government of a foreign country of concern does not have a controlling interest in Entity.

C. Entity is not organized under the laws of, and does not have a principal place of business in, a foreign country of concern.

D. Entity is not owned or controlled by the government of a foreign country of concern, as defined in Section 692.201, Florida Statutes.

E. Entity is not a partnership, association, corporation, organization, or other combination of persons organized under the laws of or having its principal place of business in a foreign country of concern, as defined in Section 692.201, Florida Statutes, or a subsidiary of such entity.

F. Entity is not a foreign principal, as defined in Section 692.201, Florida Statutes.

G. Entity is in compliance with all applicable requirements of Sections 692.202, 692.203, and 692.204, Florida Statutes.

39. *Annual Budgetary Funding/Cancellation.* This Agreement and all obligations of the City hereunder requiring the expenditure of funds are subject to and contingent upon annual budgetary funding and appropriations by the City Commission.

40. *Severability.* Should any provision of this Agreement or the applications of such provisions be rendered or declared invalid by a court action or by reason of any existing or subsequently enacted legislation, the remaining provisions of this Agreement shall remain in full force and effect.

**THE REMAINDER OF THE PAGE IS INTENTIONALLY LEFT BLANK**

**IN WITNESS WHEREOF**, the parties hereto have caused this Agreement to be executed the day and year hereinabove written.

Attest:

**CITY OF POMPANO BEACH**

\_\_\_\_\_  
KERVIN ALFRED, CITY CLERK

By: \_\_\_\_\_  
REX HARDIN, MAYOR

By: \_\_\_\_\_  
GREGORY P. HARRISON, CITY MANAGER

APPROVED AS TO FORM:

\_\_\_\_\_  
MARK E. BERMAN, CITY ATTORNEY

(SEAL)

**"CONTRACTOR"**

**AETNA Life Insurance Company**

Witnesses:

Anna Schmidt

Anna Schmidt

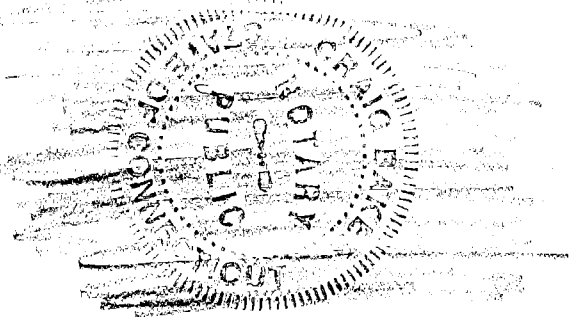
Demitria Samuel  
Demitria Samuel

By: Catherine Aguirre  
Catherine Aguirre  
Market Head of Sales & Service

STATE OF Connecticut  
COUNTY OF Hartford

~~The foregoing~~ instrument was acknowledged before me, by means of  physical presence or online notarization this 16 day of June, 2026, by Craig Baker as Project Manager of AETNA Life Insurance Company, a Connecticut corporation on behalf of the corporation, who is personally known to me.

NOTARY'S SEAL:



Craig Baker  
NOTARY PUBLIC, STATE OF Connecticut  
My Commission expires 08/31/28  
Craig Baker  
SNPC 0164929  
Commission Number

**CRAIG BAKER**  
NOTARY PUBLIC  
State of Connecticut  
My Commission Expires  
August 31, 2028

## **Exhibit “A” – Cover Page**

1. Recommendation Tabulation
2. Solicitation RFP26-035
3. Addendums 1-3
4. Online Q&A
5. Public Q&A

RFP #:	<u>RFP26-035</u>	Tentative City Commission Meeting Date*:	<u>TBD</u>
RFP Title:	<u>Employee Medical Benefits Program (Fully Insured and Self-Funded Options)</u>	# Notified:	<u>443</u> # Downloaded: <u>6</u>
		# of Responses Rec'd:	<u>6</u> # of "No Bids": <u>1</u>
For:	<u>Human Resources Department</u> (Department)	RFP Opening Date:	<u>04/27/2026</u>

**POSTING OF RFP RECOMMENDATION/TABULATION:** RFP Recommendations and Tabulations will be posted in the eBid System IonWave and will remain posted for 72 hours. Any person who may be adversely affected by the decision or intended decision shall file a notice of protest in writing within 72 hours of posting the notice of the decision or intended decision. The formal written protest shall be filed within ten (10) days after the date the notice of protest is filed. Failure to file a notice of protest or a formal written protest shall constitute a waiver of proceedings under this chapter. Section 120.57(3)(b), Florida Statutes, states that "The formal written protest shall state with particularity the facts and law upon which the protest is based." Saturdays, Sundays, state holidays, and days when the City is closed shall be excluded from the computation of the 72-hour time period provided. Filings shall be at the office of the Director of Procurement and Contracts, 1101 NE 5th Avenue, Pompano Beach, FL 33060. Any person who files an action protesting an intended decision shall post with the City, at the time of filing the formal written protest, a protest bond, payable to the City of Pompano Beach, Florida, in an amount equal to one percent (1%) of the estimated value of the contract. Failure to submit the protest bond within the time allowed for filing a bond shall constitute a waiver of the right to protest. Failure to file a protest within the time prescribed in Section 120.57(3), Florida Statutes, or failure to post the protest bond or other security required by law within the time allowed for filing a bond shall constitute a waiver of proceedings under Chapter 120, Florida Statutes.

(\* ) The "Cone of Silence" shall terminate upon the City's award or approval of a contract, rejection of all proposals or responses, or any other formal action that concludes the solicitation or other procurement process. For confirmation of the official termination date of the Cone of Silence, contact the Purchasing Agent of record.

### RECOMMENDATION TABULATION

The City of Pompano Beach, Florida, received six (6) proposals for RFP26-035 Employee Medical Benefits Program (Fully Insured and Self-Funded Options) from the following vendors: Aetna, AvMed Inc., Cigna Health and Life Insurance, Curative - Curative Insurance Company, Florida Blue, and United Healthcare Insurance Company.

On May 6, 2026, the Evaluation Committee reviewed each responsive proposal, including the proposed rates, fees, plan structure, and overall comparison to the City's current health insurance program. After reviewing the proposed rates and fees in comparison with the City's current program, the Evaluation Committee determined that (4) four firms should be shortlisted for the next phase of evaluation.

The Evaluation Committee passed a motion to shortlist the following four firms for vendor presentations being held on May 20, 2026:

- Aetna
- Cigna Health and Life Insurance
- Florida Blue
- United Healthcare Insurance Company

On May 20, 2026, a presentation evaluation meeting was held to determine the award for RFP26-035, Employee Medical Benefits Program (Fully Insured and Self-Funded Options). Based on the proposals and oral presentations, the committee members used the scoring criteria outlined in section 7.3 of the solicitation to provide final rankings. After all ranking totals were provided, it is the recommendation of the committee to bring to the City of Pompano Beach Commission, 'Aetna' for award.

Company Name	Ranking Total
Aetna	1 <sup>st</sup> – 356 points
Cigna Health and Life Insurance	2 <sup>nd</sup> – 295 points



Florida's Warmest Welcome

Procurement and Contracts Department

Mary Rivero, Director

[mary.rivero@copbfl.com](mailto:mary.rivero@copbfl.com)

<b>Florida Blue</b>	<b>3<sup>rd</sup> – 291 points</b>
<b>United Healthcare Insurance Company</b>	<b>4<sup>th</sup> – 282 points</b>

By:

*Michael Lee*

Date:

05/21/2026

(Purchasing Agent)



Florida's Warmest Welcome



**Florida's Warmest Welcome**

**REQUEST FOR PROPOSALS (RFP)**

**RFP26-035 - Employee Medical Benefits Program (Fully Insured and Self-Funded Options)**

**PROPOSAL OPENING: April 22, 2026, at 2:00 PM**

**Virtual Zoom Meeting**

**For access, go to:**

**<https://www.pompanobeachfl.gov/meetings>**



March 19, 2026

Dear Prospective Proposers,

**SUBJECT:** REQUEST FOR PROPOSALS (RFP) RFP26-035 - Employee Medical Benefits Program (Fully Insured and Self-Funded Options)

The City of Pompano Beach is soliciting experienced and qualified firms that demonstrate the highest level of ability to provide the following lines of coverage:

- Medical Insurance with the following funding arrangement:
  - Fully-Insured
  - Self-Insured
  - Medical Insurance (Fully Insured and Self-Funded)
  - Pharmacy Benefit Management Services (if applicable)
  - Stop Loss Insurance (if applicable)

Proposers must be registered on the City's eBid System to view the solicitation documents and respond to this solicitation. The complete solicitation document can be downloaded free of charge from the eBid System at <https://pompanobeachfl.ionwave.net/>. Proposals must bear the electronic signature of an authorized officer of the Proposer who is legally authorized to enter into a contractual relationship in the Proposer's name. The City will consider the submittal of a Proposal as constituting an offer by the Proposer to perform the required services at the prices stated herein. The City is not responsible for the accuracy or completeness of any documentation the Proposer receives from any source other than the eBid System. The Proposer is solely responsible for downloading all required documents. Responses will be electronically unsealed in a public forum and read aloud.

Proposals must be submitted electronically at (<https://pompanobeachfl.ionwave.net/>), referred to hereinafter as the eBid System, on or before the date and time stated in **Section 1 —Schedule of Events. Proposals received after 2:00:00 p.m. ET on the due date will not be considered, and late bids will not be accepted.**

Cone of Silence shall take effect once this solicitation is released to the General Public and shall remain in effect until the City Commission has taken final action to approve or reject an award, or otherwise terminate the solicitation. During the Cone of Silence period, Respondents to this solicitation, or persons acting on their behalf, including lobbyists, shall not communicate, directly or indirectly, regarding any aspect of this solicitation with any member of the City Commission, the City Clerk, the City Manager's Office, any Evaluation Committee member, or any other City of Pompano Beach employee, except in writing to the Procurement and Contracts Department staff as expressly permitted in this solicitation. Violation of the Cone of Silence may be grounds for rejection of a Proposal or other appropriate action as permitted by City ordinance.

All communications regarding this solicitation must be submitted through the City's eBid System (IonWave) or directed to the assigned Purchasing Agent, Eric Seifer, at (954)786-4166, or [eric.seifer@copbfl.com](mailto:eric.seifer@copbfl.com). Unauthorized contact may result in disqualification.

Any information that amends any portion of this solicitation received by any method other than an Addendum issued through Ionwave is not binding on the City of Pompano Beach.

Carefully read all portions of the RFP document to ensure the Proposer's bid fully complies with all requirements.

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1. **SCHEDULE OF EVENTS**

<b>RFP Number:</b>	<b>RFP26-035</b>
<b>RFP Title:</b>	<b>Employee Medical Benefits Program (Fully Insured and Self-Funded Options)</b>
<b>Release Date:</b>	<b>March 19, 2026</b>
<b>Date Published In Sun-Sentinel</b>	<b>March 23, 2026</b>
<b>Deadline for Receipt of Written Questions:</b>	<b>April 9, 2026, at 5:00 PM</b>
<b>Deadline for Carriers to Submit Proposals:</b>	<b>April 22, 2026, at 2:00 PM</b>
<b>Evaluation Committee Meetings</b>	<b>TBD</b>
<b>Recommendation For Award:</b>	<b>TBD</b>
<b>Open Enrollment Period:</b>	<b>July 20, 2026 – July 31, 2026</b>
<b>All Data to Carrier(s)</b>	<b>TBD</b>
<b>Plan Effective Date</b>	<b>October 1, 2026</b>
<b>Direct All Inquiries To:</b>	<b><a href="https://pompanobeachfl.ionwave.net">https://pompanobeachfl.ionwave.net</a></b>
<b>Electronic Proposal Submittals Only:</b>	<b><a href="https://pompanobeachfl.ionwave.net">https://pompanobeachfl.ionwave.net</a></b>
<b>Proposal Virtual Opening:</b>	<b><a href="https://www.pompanobeachfl.gov/meetings">https://www.pompanobeachfl.gov/meetings</a></b>

**This timeline is subject to change.**

## **2. INTRODUCTION AND GENERAL INFORMATION**

### **2.1. Scope and Purpose**

The specifications include the complete set of requirements and Proposal forms. Complete all Proposal forms as specified and include the forms with your Proposal. Failure to include Proposal forms may be grounds for disqualification from this RFP Process.

### **2.2. Intent of RFP**

The City of Pompano Beach is soliciting medical coverage, including fully insured and self-insured options, coverage for City of Pompano Beach employees, officials, retirees, COBRA participants and their families. The City of Pompano Beach's goal is directed toward the highest professional level of service while providing access to a quality network of providers at an affordable cost.

### **2.3. Renewal**

The awarded firm shall give a minimum of one hundred twenty (120) days' written notice prior to any renewal date to the City of Pompano Beach stating specifically what, if any, rate change is proposed.

### **2.4. Recommended Rate Guarantee Terms**

- Medical: 12 Months
- ASO: 36 Months

### **2.5. Interviews**

Proposers may be asked to attend an interview in support of their Proposal or to explain or demonstrate the information contained therein.

### **2.6. Public Records Law**

Upon award recommendation or thirty (30) days after opening, whichever is earlier, any material submitted in response to this RFP will become a public record and shall be subject to public disclosure consistent with Chapter 119, Florida Statutes. Proposers must claim any applicable exemptions to disclosure provided by law in their response by clearly identifying materials claimed to be exempt and stating the legal basis for such exemption. The City reserves the right to make the final determination regarding the applicability of any claimed exemption.

### **2.7. Disclosure of Proposal Contents**

All material submitted becomes the property of the City of Pompano Beach. The City of Pompano Beach has the right to use any or all ideas presented in any reply to this RFP. Selection or rejection of the Proposal does not affect this right.

### **2.8. Term of Contract**

The City anticipates awarding a Service Agreement for an initial term of five (5) years. The Agreement may be renewed for up to two (2) additional one-year terms, subject to City Commission approval. Proposers shall honor and maintain the premium rates, administrative fees, and other pricing proposed in response to this RFP for the full duration of the rate guarantee period(s) offered in their Proposal. After the expiration of the applicable rate guarantee period(s), any adjustment to rates, fees, or pricing shall be subject to negotiation and may only be implemented by mutual written amendment to the Agreement, approved in accordance with City requirements. Except as otherwise amended in writing, all remaining terms and conditions shall continue in effect for the duration of the Agreement and any approved renewal term(s). The City also reserves the right, at its sole discretion, to extend the Agreement for a period not to exceed one hundred eighty (180) days, under the same terms, conditions, and pricing then in effect, if necessary to ensure continuity of services. The City reserves the right to rebid, re-solicit, or renegotiate any portion of the services covered under this Agreement if market conditions, program needs, funding strategy, or operational requirements materially change during the term of the Agreement.

## **2.9. Proposal Submittal Due Date**

The City will receive sealed Proposals by **April 22, 2026, at 2:00 PM local time**. Proposals must be submitted electronically through the eBid System on or before the due date/time stated above. Any Proposal received after the due date will not be considered.

## **2.10. Questions and Communication**

<http://www.pompanobeachfl.ionwave.net> is the official method used by the Procurement and Contracts Department, which has approved the distribution and communication of all competitive solicitations. All questions regarding this RFP must be submitted using the Questions feature in the eBid System on or before **April 9, 2026, at 5:00 PM** via <http://www.pompanobeachfl.ionwave.net/>. Questions received after this date and time will not be answered. Questions submitted by Proposers will be answered through the Ionwave Questions feature or via Addenda, if necessary. Any verbal or written information obtained from sources other than the information included in this RFP document or by an Addendum shall not be binding on the City.

### **3. VENDOR REQUIREMENTS**

The City intends to award one or more contracts for fully insured medical coverage and/or administrative services-only (ASO) arrangements, including related services such as stop-loss insurance and pharmacy benefit management, as applicable.

The selected Proposer shall provide employee medical benefits program services for the City of Pompano Beach, including fully insured and self-funded medical plan options, implementation support, open enrollment assistance, employee communications, eligibility file integration, ongoing account management, reporting, wellness program support, and all related administrative services necessary to deliver the proposed coverage.

#### **3.1. Proposal Effective Date: October 1, 2026**

#### **3.2. Commissions:**

Proposals should include the following commission rates in the respective lines of coverage:

- Medical: Net of Commissions

#### **3.3. Retirees:**

Florida Governmental Retirees must be allowed to continue coverage under the City of Pompano Beach's insurance program as required by Florida Statutes 112.08.

#### **3.4. Governmental Entity Requirements:**

As a condition of responding to this Request for Proposal, the Medical/Rx Carrier understands and acknowledges that, as a public sector governmental entity, the City is not subject to ERISA and, as such, is subject to state insurance laws, including, but not limited to, the requirements of Section 626.8825, Florida Statutes. The Medical/Rx Carrier further represents that it is in compliance with the terms and conditions of the Florida Prescription Drug Act and that nothing regarding the Medical/Rx Carrier's network, compensation, pricing, or administrative structure would prohibit the City from submitting the attestation of compliance thereunder, as required by law. Where requested by the City, the Medical/Rx Carrier shall submit such attestation on the City's behalf. The Medical/Rx Carrier agrees to indemnify the City from any and all losses arising from the Medical/Rx Carrier's failure to structure its administrative processes in a manner that complies with the Florida Prescription Drug Act.

#### **3.5. Reference Requirement:**

It is a requirement that all insurance carriers currently provide group insurance to at least two other Municipal entities with at least 500 employees. Proposers not able to list two current Municipal references may be disqualified from consideration.

#### **3.6. Benefit Plan Design:**

Proposers are encouraged to match current plan designs as closely as possible.

#### **3.7. Wellness Incentive Program:**

Please outline, in detail, your proposed Wellness Program and any resources available to the City of Pompano Beach (including Mental Health wellness resources). Please also include a minimum of \$100,000 in annual Wellness Funds.

#### **3.8. Technology Funds:**

Proposers are encouraged to include technology funds in their Proposal.

#### **3.9. Guarantees:**

Proposers are encouraged to include performance guarantees, implementation guarantees, service guarantees, and network discount guarantees.

#### **3.10. Rate Guarantees:**

The City of Pompano Beach highly recommends Proposals for ASO to provide multiple-year rate guarantees.

### **3.11. Plan Implementation:**

It is a requirement that the Proposer awarded this contract provide representative(s) to assist with implementation, open enrollment, employee communications, and ongoing assistance with routine plan administration.

### **3.12. Employee Communications:**

It is the responsibility of all successful Proposers to provide the necessary papers, forms, etc., for initial enrollment and also the administration of benefits including but not limited to: brochures outlining schedule of benefits, directories, certificates, claim forms, identification cards, benefit booklets, etc., where applicable.

### **3.13. Benefit Administration:**

The City of Pompano Beach uses Bentek for online enrollment and electronic administration of its benefit programs. All Proposers must have the technological capacity to transmit and accept a HIPAA 834 5010 eligibility file with proper confirmation of receipt and discrepancy reporting.

- If the selected provider has an existing data exchange process with Bentek, that process will continue, including file layouts, timing, and method of transmitting data. For those providers that do not have an existing data exchange process with Bentek, Bentek will require that the utilization of the Bentek standard file layout and FTP site be the method of data transmission. Eligibility files, including employee terminations, are provided on a per-payroll basis.

**4. BACKGROUND & UNDERWRITING INFORMATION**

**4.1. Background Summary**

Medical is offered through Florida Blue

**4.2. Medical Rate History**

	2021	2022	2023	2024	2025
<b>BlueCare HMO 55</b>	<b>FL Blue</b>	<b>FL Blue</b>	<b>FL Blue</b>	<b>FL Blue</b>	<b>FL Blue</b>
Employee Only	\$657.84	\$657.84	\$722.31	\$756.96	\$756.96
Employee + Family	\$1,763.07	\$1,763.07	\$1,935.85	\$2,028.72	\$2,028.72
<b>BlueChoice PPO 0727</b>	<b>FL Blue</b>	<b>FL Blue</b>	<b>FL Blue</b>	<b>FL Blue</b>	<b>FL Blue</b>
Employee Only	\$968.42	\$968.42	\$1,063.33	\$1,114.34	\$1,114.34
Employee + Family	\$2,223.47	\$2,223.47	\$2,441.59	\$2,558.72	\$2,558.72
<b>BlueChoice PPO 0727 (Retirees O65)</b>	<b>FL Blue</b>	<b>FL Blue</b>	<b>FL Blue</b>	<b>FL Blue</b>	<b>FL Blue</b>
Employee Only	\$726.32	\$726.32	\$797.50	\$835.76	\$835.76
Employee + Spouse	\$1,452.63	\$1,452.63	\$1,594.99	\$1,611.51	\$1,611.51
Employee + Family	\$1,981.57	\$1,981.57	\$2,175.76	\$2,280.14	\$2,280.14

**4.3. Employee Eligibility:**

Employees are eligible to participate in the City of Pompano Beach's insurance plans if they are full-time employees working a minimum of 30 hours per week. Coverage will be effective on the first day of the month following 60 days of full-time employment.

**4.4. Employer Contributions Strategy:**

<b>FL Blue – BlueCare HMO 55</b>	<b>Employee</b>	<b>Employer</b>
Employee	\$0.00	\$756.96
Employee + Family	\$635.88	\$1,392.84
<b>FL Blue – BlueChoice PPO 0727</b>	<b>Employee</b>	<b>Employer</b>
Employee	\$0.00	\$1,114.34
Employee + Family	\$722.19	\$1,836.53
<b>FL Blue – BlueChoice PPO 0727 (Retirees O65)</b>	<b>Employee</b>	<b>Employer</b>
Employee	\$835.76	\$0.00
Employee + Spouse	\$1,671.51	\$0.00
Employee + Family	\$2,280.14	\$0.00

## **5. SUBMITTAL INSTRUCTIONS AND REQUIREMENTS**

### **5.1. Submission Format Requirements**

Proposals must be submitted electronically through the eBid System (<https://pompanobeachfl.ionwave.net>) on or before the date and time stated in Section 1, Schedule of Events. Please follow all the steps and requirements to submit Proposals at <http://www.pompanobeachfl.ionwave.net/>. Submissions must include all documents, requirements, and attachments advertised on the website, as listed in the Attributes tab and the Response Attachments tab of the eBid System.

The City will not be responsible for delays caused by technical or other issues. It is the sole responsibility of the Proposer to ensure its Proposal is successfully submitted in the eBid System before the established deadline for Proposal submission.

The City reserves the right to reject and not consider any Proposals that are not submitted according to the requirements established herein.

### **5.2. Proposer's Responsibilities**

Before submitting a response, the Proposer shall be solely responsible for conducting any necessary investigations, evaluations, and examinations to ascertain all conditions and requirements affecting the full performance of the Contract. Ignorance of such conditions and requirements, and/or failure to make such evaluations, investigations, and examinations, will not relieve the Proposer from any obligation to comply with every detail and with all provisions and requirements of the Contract and will not be accepted as a basis for any subsequent claim whatsoever for any monetary consideration on the part of the Proposer.

### **5.3. Costs Incurred by the Proposer in Preparation of the Proposal**

Proposers are responsible for any and all costs associated with responding to this RFP. The City will not reimburse any Proposer for preparation, submittal, travel, or per diem costs. All expenses involved with the preparation and submission of Proposals, or any work performed in connection with this solicitation, shall be the sole responsibility (and shall be at the sole cost and expense) of the Proposer and shall not be reimbursed by the City.

### **5.4. Composition Of Project Team**

The principals and personnel named in the Proposal must perform the services throughout the contractual term, unless otherwise provided for by a negotiated contract or a written amendment to the same, executed by both parties. No diversion or substitution of principals or personnel will be allowed unless a written request that sets forth the qualifications and experience of the proposed replacement(s) is submitted to and approved by the City in writing.

## **6. PROPOSAL REQUIREMENTS AND EVALUATION CRITERIA**

This section identifies the information required to determine whether Proposals are complete and responsive, as well as the information that will be used in the evaluation of Proposals in accordance with the criteria identified in Section 7.3. Proposers shall ensure that their submissions clearly and fully address each evaluation criterion. Failure to provide complete and detailed responses may result in reduced scoring, a determination of non-responsiveness, or disqualification, as applicable.

To maintain comparability and facilitate the review process, Proposals should be organized in the following order:

### **6.1. Title page:**

Show the project name and solicitation number, the name of the Proposer's firm, business address, telephone number, name, title, email address, and phone number of the primary contact person, and the date.

### **6.2. Table of Contents:**

Include a clearly organized table of contents that identifies sections and their corresponding page numbers.

### **6.3. Letter of Interest:**

Submit a Letter of Interest, signed by an authorized representative of the Proposer's firm, expressing the Proposer's commitment to provide the services described herein. In the letter, include:

- Legal name of the Proposer and any joint venture partners (if applicable)
- Federal Tax Identification Number
- Office address
- Primary Contact name, title, phone number, and email

### **6.4. Premium Cost Proposal:**

Proposers shall provide complete premium rate information for both PPO and HMO plans, including employee and dependent combined costs, as required in the Proposal rate sheets. All pricing must be clearly presented and consistent with the submitted rate sheets. Complete the Proposal rate sheets included in the Attachments tab of IonWave and include them with the Proposal. Proposers shall also itemize all costs necessary to provide the services described in Section 3, Vendor Requirements.

### **6.5. Qualifications of Personnel:**

Proposers shall identify key personnel assigned to the City's account, including account managers, implementation specialists, customer service representatives, and any other support staff. For each individual, provide qualifications, relevant experience, certifications, and tenure with the organization.

### **6.6. Availability of Personnel:**

Proposers must also describe staffing levels, personnel availability for ongoing support, responsiveness standards, and escalation procedures. The Proposal should clearly demonstrate the Proposer's ability to provide sufficient, experienced personnel to ensure successful implementation, administration, and ongoing service of the program.

### **6.7. Prior Experience and Reference Satisfaction:**

Proposers shall describe their firm's prior experience providing group health benefits coverage and related administrative services for governmental or similarly sized public sector clients. Include the number of years providing such services, experience with fully insured and self-funded arrangements, and evidence of client satisfaction, including references, retention history, performance outcomes, or other relevant indicators.

### **6.8. References:**

It is a requirement that all insurance carriers currently provide group insurance to at least two (2) Municipal entities with a minimum of 500 employees. Proposers not able to list two current Municipal references may be disqualified from consideration.

Submit a client reference list, including the name of the contact, firm, and/or governmental entity, address, telephone number, email address, and type of service provided, and years of service provided to each reference.

**6.9. Benefits Equal to or Better Than Current Plan:**

Proposers are encouraged to match current plan designs as closely as possible. Proposers shall provide a detailed comparison of their proposed benefit plans to the City's current plan designs, clearly identifying any differences, enhancements, or limitations. The comparison should include deductibles, copayments, coinsurance, out-of-pocket maximums, covered services, exclusions, and prescription drug coverage. Proposers must demonstrate how their proposed plans are equal to or exceed the current benefits offered by the City and describe any added value, cost efficiencies, or innovative plan features that improve overall coverage or member experience.

**6.10. Referral System:**

Proposers shall describe their referral procedures, including how referrals are initiated, processed, tracked, and communicated to members and providers. The response should address requirements for specialist referrals, authorization processes, ease of use for members, and any digital tools or platforms that support the referral process. Proposers should also explain how their referral system minimizes administrative burden, reduces delays in care, and ensures timely access to appropriate medical services.

**6.11. Provider Network:**

Proposers shall submit a comprehensive provider network analysis, including an interruption report and access analysis, demonstrating the availability and accessibility of participating providers for the City's employees and dependents. The analysis should include the percentage of current providers that are in-network, geographic coverage within Broward County and surrounding areas, and access to primary care physicians, specialists, hospitals, and ancillary services. Proposers should also describe network stability, strategies for minimizing disruption, and any network expansion initiatives. Proposers shall include an interruption report and analysis identifying the extent to which currently utilized providers and facilities participate in the proposed network.

**6.12. System for Paying Claims:**

Proposers shall describe in detail their claims administration process, including claim intake, adjudication procedures, payment timelines, accuracy controls, and audit mechanisms. The response should include average turnaround times, electronic claims capabilities, coordination of benefits processes, fraud detection measures, and compliance with applicable federal and state regulations. Proposers should also describe their reporting capabilities, the transparency of their claims data, and any tools available to the City for monitoring claims activity and financial performance.

**6.13. Questionnaire and Fact Sheet:**

Provide responses to all items listed in the City's Questionnaire and Fact Sheet included in the Attachments tab of the eBid System, and include the completed documents with your Proposal.

**6.14. Contract:**

Please include your carrier standard contract in Word Document format with the RFP for the City of Pompano Beach's review.

**6.15. Wellness Incentive Program:**

Please outline, in detail, your proposed Wellness Program and any resources available to the City of Pompano Beach (including Mental Health wellness resources). Please also include a minimum of \$100,000 in annual Wellness Funds.

**6.16. Technology Funds:**

Proposers are encouraged to include technology funds in their Proposal.

**6.17. Guarantees:**

Proposers are encouraged to include performance guarantees, implementation guarantees, service guarantees, and network discount guarantees.

**6.18. Rate Guarantees:**

The City of Pompano Beach highly recommends Proposals for ASO to provide multiple-year rate guarantees.

**6.19. Plan Implementation:**

It is a requirement that the Proposer awarded this contract provide representative(s) to assist with implementation, open enrollment, employee communications, and ongoing assistance with routine plan administration.

**6.20. Conflicts of Interest:**

Provide the name(s) of any officer, director, agent, or immediate family member (spouse, parent, sibling, and child) who is also an employee, elected or appointed official of the City of Pompano Beach. Further, the Proposer must disclose the name of any City employee, elected or appointed official who owns, either directly or indirectly, an interest of ten (10%) percent or more in the Proposer entity or any of its affiliates.

**6.21. Litigation:**

Disclose any litigation within the past five (5) years of the firm's/team member's performance, including status/outcome. If there is no litigation, the Proposer must include a letter that no litigation exists within the past (5) years.

**6.22. Local Business Program (Maximum 5 points)**

The Procurement and Contracts staff will evaluate this section. On March 13, 2018, the City Commission approved Ordinance 2018-46, establishing a Local Business Program, a policy to increase the participation of City businesses in the City's procurement process.

For purposes of this solicitation, "Local Business" will be defined as follows:

TIER 1 LOCAL VENDOR.

POMPANO BEACH BUSINESS EMPLOYING POMPANO BEACH RESIDENTS. A business entity that has maintained a permanent place of business within the City limits and maintains a staffing level, within this local office, of at least ten percent who are residents of the City, or includes subcontracting commitments to Local Vendors Subcontractors for at least ten percent of the contract value. The permanent place of business may not be a post office box. The business must be located in a non-residential zone and must actually distribute goods or services from that location. The business must be staffed with full-time employees within the limits of the City. In addition, the business must have a current business tax receipt from the City for a minimum of one year prior to the date of issuance of a solicitation.

TIER 2 LOCAL VENDOR.

BROWARD COUNTY BUSINESS EMPLOYING POMPANO BEACH RESIDENTS OR UTILIZING LOCAL VENDOR SUBCONTRACTORS. A business entity, which has maintained a permanent place of business within Broward County and maintains a staffing level, within this local office, of at least 15% who are residents of the City, or includes subcontracting commitments to Local Vendors Subcontractors for at least 20% of the contract value. The permanent place of business may not be a post office box. The business must be located in a non-residential zone and must actually distribute goods or services from that location. The business must be staffed with full-time employees within the limits of the City. In addition, the business must have a current business tax receipt from the respective Broward County municipality for a minimum of one year prior to the date of issuance of a solicitation.

LOCAL VENDOR SUBCONTRACTOR.

POMPANO BEACH BUSINESS. A business entity that has maintained a permanent place of business within

the City limits of the City. The permanent place of business may not be a post office box. The business must be located in a non-residential zone and must actually distribute goods or services from that location. The business must be staffed with full-time employees within the limits of the City. In addition, the business must have a current business tax receipt from the City for a minimum of one year prior to the date of issuance of a solicitation.

You can view the list of City businesses with a current Business Tax Receipt on the City's website and locate local companies that are available to perform the work required by the RFP scope of services. The business information, sorted by business use classification, is posted on the Business Tax Receipt Division webpage: [www.pompanobeachfl.gov](http://www.pompanobeachfl.gov) by selecting the Pompano Beach Business Directory in the Shop Pompano! Section.

The City is **strongly committed** to ensuring the participation of City Businesses as contractors and subcontractors for procuring goods and services, including labor, materials, and equipment.

Proposers are required to participate in the City's Local Business Program by including, as part of their package, the Local Business Participation Form (Exhibit A), listing the local businesses that will be used on the contract, and the Letter of Intent Form (Exhibit B) from each local business that will participate in the contract.

If a Prime Contractor/Vendor is not able to achieve the level of goal attainment of the contract, the Prime Vendor will be requested to demonstrate and document that good faith efforts were made to achieve the goal by providing the Local Business Unavailability Form (Exhibit C), listing companies that were contacted but not available, and the Good Faith Effort Report (Exhibit D), describing the efforts made to include local business participation in the contract. This documentation shall be provided to the City Commission for acceptance.

The awarded Proposer will be required to submit "Local Business Subcontractor Utilization Reports" during projects and after projects have been completed. The reports will be submitted to the assigned City project manager. The Local Business Subcontractor Utilization Report template and instructions have been included in the bid document.

Failure to meet Local Vendor Goal commitments will result in an "unsatisfactory" compliance rating. Unsatisfactory ratings may impact the award of future projects if a sanction is imposed by the City Commission.

The City shall award a Local Vendor preference based upon vendors, contractors, or subcontractors who are local, with a preference as follows:

For evaluation purposes, the Tier 1 and Tier 2 businesses shall be a criterion for award in this Solicitation. No business may qualify for more than one tier level.

For evaluation purposes, local vendors shall receive the following preferences:

Tier 1 business, as defined by this subsection, shall be granted a preference in the amount of 5 Points.

Tier 2 business, as defined by this subsection, shall be granted a preference in the amount of 2.5 Points.

It is the responsibility of the awarded vendor/contractor to comply with all Tier 1 and Tier 2 guidelines. The awarded vendor/contractor must ensure all requirements are met before contract execution.

**PROPOSERS APPLYING FOR TIER 1 STATUS, OR THOSE LISTING LOCAL SUBCONTRACTORS OR SUBCONSULTANTS IN EXHIBIT A, MUST PROVIDE A VALID CITY OF POMPANO BEACH BUSINESS TAX RECEIPT FOR THE PROPOSER AND FOR EACH LOCAL SUBCONTRACTOR OR SUBCONSULTANT IDENTIFIED. FAILURE TO INCLUDE THE REQUIRED BUSINESS TAX RECEIPT(S) WILL RESULT IN THE DISQUALIFICATION OF THE SUBCONTRACTOR OR SUBCONSULTANT FROM THE LOCAL BUSINESS PROGRAM AND THE LOSS OF ALL ASSOCIATED POINTS.**

**IF A PROPOSER IS NOT CLAIMING PARTICIPATION IN ANY LOCAL BUSINESS PROGRAM TIER, THE REQUIRED FORMS (EXHIBITS A THROUGH D, AS APPLICABLE) MUST STILL BE SUBMITTED AND CLEARLY MARKED “NOT APPLICABLE” THROUGHOUT. PROPOSALS SUBMITTED WITHOUT THE REQUIRED DOCUMENTATION WILL BE DEEMED NON-RESPONSIVE AND INELIGIBLE FOR AWARD.**

**6.23. Other Required Documentation**

The following documents are required to determine whether the Proposal meets the minimum requirements. However, these documents will not be considered when scoring the Proposal.

**6.23.1. City Forms:**

Responses should include all pages of this solicitation, completed where indicated, and completed Local Business forms. These forms are included in this RFP and available as attachments to the eBid System. These forms must be completed electronically in the Attributes tab or uploaded to the Response Attachments tab of the eBid System.

**6.23.2. Insurance**

Please see Exhibit B with the Insurance Requirements in the Attachments tab of the eBid System.

## **7. EVALUATION AND AWARD**

### **7.1. Minimum Eligibility Requirements**

All Proposals received must meet the minimum eligibility requirements as required in Section 6 and be confirmed at the time of submission to be considered for further evaluation. Failure to meet the Minimum Eligibility Requirements may disqualify the entire Proposal and prevent it from being considered for further evaluation.

The City reserves the right to seek any information or documentation from the Proposer or other source(s) as the City determines is necessary. Failure to submit any additional information in accordance with the City's request shall result in a Proposal being deemed non-compliant by the City of Pompano Beach. The City reserves the right to determine whether any omission, deficiency, or deviation is material or minor and whether waiver is in the best interest of the City.

### **7.2. Evaluation Committee**

Only Proposals determined by the Procurement and Contracts Department to be compliant with the submission requirements and Minimum Eligibility Requirements of this RFP will be forwarded to the Evaluation Committee for evaluation.

The City Manager will approve a selection Evaluation Committee to assist in evaluating the received Proposal(s) and selecting the most qualified company or firm. The Committee's findings will be presented to the City Commission. Based upon the evaluation, the Evaluation Committee will recommend one or more Proposers to the City Commissioners for the award and execution of a Service Agreement.

### **7.3. Evaluation Process - Presentations**

The Procurement and Contracts Department staff will initiate an administrative review of the Proposals to determine compliance with the submission requirements and Minimum Eligibility Requirements set forth in this RFP. All Proposals determined to be compliant and eligible for evaluation will be provided to the Evaluation Committee. The Evaluation Committee will score the Proposals based on the following:

Criteria	MAXIMUM POINTS
Prior Experience and Reference Satisfaction	10
Benefits Equal to or Better Than Current Plan	15
Provider Network	15
Qualifications of Personnel	15
Availability of Personnel	15
System for Paying Claims	10
Referral System	5
Premium Cost PPO (Employee/Dependent Combined)	5
Premium Cost HMO (Employee/Dependent Combined)	5
Local Business Program	5

The Evaluation Committee reserves the right to shortlist the Proposals received and/or to request oral presentations from the Proposers. If the Evaluation Committee requests presentations, they will be scheduled at a later date. Each invited Proposer will be provided with up to 20 minutes to present to the Evaluation Committee members, followed by a question-and-answer period. Pursuant to Section 286.0113(2)(b)1., Florida Statutes, the portion of an Evaluation Committee meeting at which a Proposer makes an oral presentation as part of this competitive solicitation may be conducted as an exempt session, limited solely to the presentation and questions directed to the presenting Proposer.

The Evaluation Committee shall rank the Proposers based on the criteria stated within this solicitation, the information provided in the Proposal, and the presentations. After all members of the Evaluation Committee have provided their scores for all Proposals, the scores will be calculated and combined, and the sum of qualitative scores will be converted into rankings. After scoring (and presentations, if any), the Committee determines final rankings and recommends an award to one or more Proposers. Based upon the final rankings, the Evaluation Committee may recommend that negotiations be conducted with one or more Proposers in ranked

order, as determined to be in the best interest of the City. If contract negotiations cannot be completed with the highest-ranked team, then negotiations may proceed to other ranked teams in accordance with applicable Florida law and City procurement procedures.

#### **7.4. Tie Breaker:**

In case there is a tie for the highest-ranked Proposers, the recommendations shall be made by giving preference to the following items in this order:

- 1) Maintenance of a Drug-Free Workplace in accordance with the requirements of 287.087, F.S.
- 2) Local Business Program Participation
- 3) Coin Toss

#### **7.5. Technicalities:**

Failure to respond, provide detailed information, or provide requested Proposal elements may result in reduced points in the evaluation process or a determination that the Proposal is non-compliant, and may be deemed a technicality or a material deviation, depending on the nature and extent of the omission.

The Procurement and Contracts Department shall conduct an administrative review of all Proposals to determine compliance with the submission requirements and Minimum Eligibility Requirements of this RFP. Proposals determined by the Procurement and Contracts Department to be non-compliant may be rejected and shall not be forwarded to the Evaluation Committee for scoring or ranking. If more than one Proposal is determined to be compliant, the Procurement and Contracts Department shall present any identified omissions, deficiencies, irregularities, or technical deviations to the Evaluation Committee.

The Evaluation Committee shall consider and rely upon the compliance determinations made by the Procurement and Contracts Department and may recommend rejection of any Proposal containing a material deviation from the requirements of this RFP or may recommend waiver of minor irregularities or technicalities when determined to be in the best interest of the City. The City reserves the right to determine whether any omission, deficiency, or deviation is material or minor and whether waiver is in the best interest of the City.

If only one (1) compliant Proposal is received, or if only one (1) compliant Proposal remains after the administrative review, the City may proceed without scoring the Proposal and may negotiate the best terms and conditions with the sole Proposer, or may reject, cancel, or reissue the solicitation, as determined to be in the best interest of the City. The negotiation of a sole compliant Proposal under this subsection is an administrative action and may occur independently of the Evaluation Committee process.

#### **7.6. Committee Questions:**

The Committee reserves the right to ask clarifying questions once Proposals have been opened, to require presentations from all Proposers, to interview any or all Proposers who respond to the RFP, or to make its recommendations based solely on the information contained in the submitted Proposals. The Committee has the option to use the above criteria for the initial ranking to short-list Proposers and to use an ordinal ranking system to score short-listed Proposers following presentations (if deemed necessary), with a score of "1" assigned to the short-listed Proposer deemed most qualified by the Committee.

Each company/firm should submit documentation that evidences the company's/firm's capability to provide the services required for the Committee's review for shortlisting purposes. After an initial review of the Proposals, the City may invite selected Proposals for an interview to discuss the Proposal and meet with the company's or firm's representatives, particularly key personnel assigned to the project. Should interviews be deemed necessary, it is understood that the City shall incur no costs as a result of this interview nor bear any obligation in further consideration of the submittal.

#### **7.7. Committee's Recommendations:**

After completion of scoring and, if applicable, presentations, the Evaluation Committee shall determine the final rankings of the Proposers. The Committee may utilize rescoring based on the published evaluation criteria or may apply an ordinal ranking methodology following presentations, as determined by the Committee.

Based upon the final rankings, the Evaluation Committee may, in its discretion, recommend an award to one (1) Proposer, or may recommend that negotiations be conducted with more than one (1) Proposer in ranked order, when determined to be in the best interest of the City. If the Committee recommends negotiations with more than one Proposer, negotiations shall proceed in ranked order. The Committee may recommend proceeding to the next highest-ranked Proposer if negotiations with a higher-ranked Proposer are unsuccessful or an impasse is reached.

Pursuant to Section 286.0113(2), Florida Statutes, the Evaluation Committee may conduct exempt negotiation sessions with ranked Proposers prior to making its recommendation for award. Any such exempt negotiation sessions shall be conducted outside the presence of the public and other Proposers. The Committee shall recess the open public portion of the meeting to conduct any exempt negotiation session(s) and shall reconvene the open public portion of the meeting upon completion.

Upon completion of its evaluation and any exempt negotiation sessions, the Evaluation Committee shall, by motion and roll call vote, make its recommendation to the City Commission. City staff may assist in documenting and presenting the Committee's recommendation to the City Commission. Final scores and rankings are used solely to establish the negotiation order and do not determine the actual award.

The negotiation of a sole compliant Proposal is an administrative action and may occur independently of the Evaluation Committee process, as determined by the City. In all cases, City staff assigned to the project and procurement retain authority to negotiate the terms and conditions of any resulting agreement, subject to final approval by the City Commission.

#### **7.8. Negotiations:**

Following the Evaluation Committee Meeting, the City reserves the right to enter into negotiations with the successful Proposer. Notwithstanding the preceding, the City is in no way obligated to enter into a Contract with any successful Proposer and may cease negotiations at any time. The Proposer also understands and acknowledges that no property, Contract, or legal rights of any kind shall be created at any time until and unless an Agreement has been agreed to, approved by the City Commission or by the City Manager if within his delegated authority, and executed by the parties. During the negotiation process, the City reserves the right to request a best and final offer from the Proposer with whom it is negotiating.

#### **7.9. Determination of Award:**

The City Commission shall consider the Committee's award recommendation for this RFP and may approve such a recommendation. The City Commission may also, at its option, reject the Evaluation Committee's recommendation, or it may also reject all Proposals, in which case the City may choose to re-advertise this project "as is" or by adopting a modified version.

## **8. STANDARD PROVISIONS**

### **8.1. RFP Conditions and Provisions**

The Proposal must be submitted to the City on or before the time and date stated herein. All Proposers, by submission of a Proposal, shall agree to comply with all of the conditions, requirements, and instructions of this RFP as stated or implied herein. All Proposals and supporting materials submitted will become the property of the City. Exceptions or deviations to this solicitation may not be added after the submittal date. All Proposers are required to provide all information requested in this RFP. Failure to do so may result in the Proposal's disqualification.

The City reserves the right to postpone or cancel this RFP or reject all Proposals if, in its sole discretion, it deems it in the City's best interest to do so. The City reserves the right to waive any technical or formal errors or omissions, reject all Proposals, or award a contract for the items herein, in part or whole, if it is determined to be in the City's best interests.

The City shall not be liable for any costs incurred by the Proposer in preparing Proposals or for any work performed therein.

### **8.2. Acceptance Period**

Proposals submitted in response to this RFP must be valid for a period of no less than one hundred eighty (180) days from the closing date of this solicitation.

### **8.3. Withdrawal Of Proposals**

A firm may withdraw its Proposal without prejudice, no later than the advertised deadline for submission of Proposals by using the eBid System or through written communication to the Procurement and Contracts Department, 1190 N.E. 3<sup>rd</sup> Avenue, Building C, Pompano Beach, Florida 33060.

### **8.4. Protest Procedures**

The Protest Procedures established within the Procurement and Contracts Procedures Manual and Section 120.57, Florida Statutes, must be followed to file a valid Protest to this solicitation. To be considered, protests concerning the proposed solicitation award must be filed in writing with the Procurement and Contracts Director. They may only be filed by bidders or Proposers whom the solicitation or award may aggrieve. The initial protest must be addressed to the following:

Director of Procurement and Contracts, City of Pompano Beach  
1190 N.E. 3rd Avenue, Building C, Pompano Beach, Florida 33060

### **8.5. Familiarity With Laws**

It is assumed the selected firm(s) will be familiar with all federal, state, and local laws, ordinances, rules, standards, and regulations that may affect its services pursuant to this RFP. Ignorance on the part of the firm will in no way relieve the firm from responsibility for compliance.

### **8.6. Staff Assignment**

The City of Pompano Beach reserves the right to approve or reject, for any reason, the Proposer's staff assigned to this project at any time. Background checks may be required at the discretion of the City.

### **8.7. Contract Terms**

The contract shall include, at a minimum, this RFP document and the successful Proposer's Proposal. The City of Pompano Beach City Attorney shall prepare the contract. If the City of Pompano Beach defends any claim, demand, cause of action, or lawsuit arising out of any act, action, negligent acts or negligent omissions, or willful

misconduct of the contractor, its employees, agents, or servants during the performance of the contract, whether directly or indirectly, the contractor agrees to reimburse the City of Pompano Beach for all expenses, attorney's fees, and court costs incurred in defending such claim, cause of action or lawsuit. The City reserves the right to rebid or renegotiate any portion of the services during the term if market conditions materially change.

#### **8.8. Waiver**

It is agreed that no waiver or modification of the contract resulting from this RFP, or of any covenant, condition, or limitation contained in it shall be valid unless it is in writing and duly executed by the party to be charged with it, and that no evidence of any waiver or modification shall be offered or received in evidence in any proceeding, arbitration, or litigation between the parties arising out of or affecting this contract, or the right or obligations of any party under it, unless such waiver or modification is in writing, duly executed as above. The parties agree that the provisions of this paragraph may not be waived except by a duly executed writing.

#### **8.9. Manner of Performance**

The Proposer agrees to perform its duties and obligations under the contract resulting from this RFP in a professional manner and in accordance with all applicable local, federal, and state laws, rules, and regulations. Proposer agrees that the services provided under the contract resulting from this RFP shall be provided by employees who are educated, trained, experienced, certified, and licensed in all areas encompassed within their designated duties. Proposer agrees to furnish the City of Pompano Beach with all documentation, certification, authorization, license, permit, or registration currently required by applicable laws, rules, and regulations. Proposer further certifies that it and its employees are now in and will maintain good standing with such governmental agencies and that it and its employees will keep all licenses, permits, registrations, authorizations, or certifications required by applicable laws or regulations in full force and effect during the term of this contract. Failure of the Proposer to comply with this paragraph shall constitute a material breach of contract.

#### **8.10. Quality**

The Proposer shall provide services in accordance with industry best practices and all applicable federal and state laws and regulations governing health benefit administration and insurance services. All deliverables, reports, communications materials, identification cards, enrollment materials, and related services shall be current, accurate, and professionally prepared.

#### **8.11. Omissions**

Any omission from the specifications or failure to expressly describe a required item or service shall not relieve the Proposer from furnishing a complete Proposal and performing all work necessary to provide the services contemplated by this RFP in accordance with industry standards and the intent of the solicitation.

#### **8.12. Hold Harmless and Indemnification**

Proposer covenants and agrees that it will indemnify and hold harmless the City and all of its officers, agents, and employees from any claim, loss, damage, cost, charge, or expense arising out of any act, action, neglect, or omission by the Proposer, whether direct or indirect, or whether to any person or property to which the City or said parties may be subject, except that neither the Proposer nor any of its subcontractors will be liable under this section for damages arising out of injury or damage to persons or property directly caused by or resulting from the sole negligence of the City or any of its officers, agents or employees.

#### **8.13. Composition Of the Project Team**

The principals and personnel named in the Proposal must perform the services throughout the contractual term unless otherwise provided for by way of a negotiated contract or written amendment to the same executed by both parties. No diversion or substitution of principals or personnel will be allowed unless a written request that sets forth the qualifications and experience of the proposed replacement(s) is submitted to and approved by the City in writing.

#### **8.14. Survivorship Rights**

This contract resulting from this RFP shall be binding on and inure to the benefit of the respective parties and their executors, administrators, heirs, personal representatives, successors, and assigns.

#### **8.15. Termination**

The City of Pompano Beach may terminate the contract resulting from this RFP without cause upon providing the contractor with at least sixty (60) days' prior written notice. Should either party fail to perform any of its obligations under the contract resulting from this RFP for a period of thirty (30) days after receipt of written notice of such failure, the non-defaulting party will have the right to terminate the contract immediately upon delivery of written notice to the defaulting party of its election to do so. The foregoing rights of termination are in addition to any other rights and remedies such party may have.

#### **8.16. Governing Law**

Any agreement resulting from this RFP shall be governed by the laws of the State of Florida, and the venue for any legal action relating to such agreement will be the 17<sup>th</sup> Judicial Circuit Court of Broward County, Florida.

#### **8.17. Relationship to the City**

It is the intent of the City, and the Proposer hereby acknowledges and agrees that the successful Proposer is considered to be an independent Contractor and that neither the Proposer nor the Proposer's employees, agents, or Contractors shall, under any circumstances, be considered employees or agents of the City.

#### **8.18. Cone of Silence**

Cone of Silence shall take effect once this solicitation is released to the General Public and shall remain in effect until the City Commission has taken final action to approve or reject an award, or otherwise terminate the solicitation. During the Cone of Silence period, Respondents to this solicitation, or persons acting on their behalf, including lobbyists, shall not communicate, directly or indirectly, regarding any aspect of this solicitation with any member of the City Commission, the City Clerk, the City Manager's Office, any Evaluation Committee member, or any other City of Pompano Beach employee, except in writing to the Procurement and Contracts Department staff as expressly permitted in this solicitation. Violation of the Cone of Silence may be grounds for rejection of a Proposal or other appropriate action as permitted by City ordinance.

#### **8.19. Communications**

No negotiations, decisions, or actions shall be initiated or executed by the Proposers as a result of any discussions with any City employee. Only those communications in writing from the City may be considered duly authorized expressions on behalf of the City. In addition, only communications from Proposers that are signed and in writing will be recognized by the City as duly authorized expressions on behalf of Proposers.

#### **8.20. Conflict Of Interest**

To determine any possible conflict of interest, each Proposer must disclose if any City employee is also an owner, corporate officer, or employee of the firm. If any City employee is an owner, corporate officer, or employee, the Proposer must file a statement with the Broward County Supervisor of Elections pursuant to § 112.313, Florida Statutes.

#### **8.21. Lobbying**

No Lobbying Permitted: As to any matter relating to this solicitation, the Proposer, project team member, or anyone representing the Proposer is advised they are prohibited from contacting or lobbying the Mayor, any City Commissioner, City employees, agents, or any other person working on behalf of the City related to or involved with this solicitation, including all members of the City and CRA advisory committees. For purposes of clarification, a team's representatives shall include, but not be limited to, the Proposer's employees, partners, attorneys, officers, directors, consultants, lobbyists, or any actual or potential subcontractor or consultant of the Proposer and the Proposer's team. All questions regarding the solicitation are to be submitted using the

Questions feature in the eBid System. Any violation of this condition may result in rejection and disqualification of the response/Proposal. **This “No Lobbying Provision” is in effect from the date of publication of the solicitation and shall terminate when the City approves the execution of a Contract with an awarded Proposer, rejects all responses, or otherwise takes action, which ends the solicitation process.**

The Proposer shall disclose any commitment, direct or indirect, financial or otherwise, made to any person, entity, institution, or association (Recipient), other than a team member identified as required by the solicitation submittal requirements, in connection with or potentially in connection with this solicitation. Because of the City’s commitment to complete transparency regarding this solicitation, the Disclosure Form shall be required to be updated to include additional Recipients, if any, up to and including the date of approval by the City Commission of the final negotiated Agreement. Additionally, all such Recipients shall be required to register as lobbyists as required by Sec. 34.402 of the City’s Code.

**8.22. Right to Inspect or Audit**

Contractor's records which shall include but not be limited to accounting records, written policies, procedures, computer records, disks and software, videos, photographs, subcontract files (including Proposals of Successful and Unsuccessful Proposers, originals, estimates, estimating worksheets, correspondence, change order files (including documentation covering negotiated settlements), and any other supporting evidence necessary to substantiate charges related to the agreement/contract (all the foregoing hereinafter referred to as "records") shall be open to inspection and subject to audit and reproduction, during normal working hours, by City's agent or its authorized representative to the extent necessary to adequately permit evaluation and verification of any invoices, payments or claims submitted by the Contractor or any of its payees pursuant to the execution of the agreement/contract. Such records subject to the examination shall also include, but are not limited to, those necessary to evaluate and verify direct and indirect costs (including overhead allocations) as they may apply to costs associated with the agreement/contract.

For the purpose of such audits, inspections, examinations, and evaluations, the City's agent or authorized representative shall have access to said records from the effective date of the agreement/contract, for the duration of the Work, and until five (5) years after the date of final payment by the City to the Contractor pursuant to the agreement/contract. The City's agent or authorized representative shall have access to the Contractor's facilities, all necessary records, and adequate and appropriate workspace to conduct audits in compliance with this article. The City's agent or its authorized representative shall give auditees reasonable advance notice of intended audits.

The Contractor shall require all subcontractors, insurance agents, and material suppliers (payees) to comply with this article's provisions by inserting the requirements hereof in any written agreement/contract. Failure to obtain such written agreements/contracts that include such provisions shall be a reason to exclude some or all of the related payees' costs from amounts payable to the Contractor pursuant to the agreement/contract.

**8.23. No Discrimination**

There shall be no discrimination as to race, sex, color, age, religion, or national origin in the operations conducted under any contract with the City.

**8.24. Drug-Free Workplace**

The selected firm(s) must verify that they will operate a “Drug-Free Workplace” as outlined in Florida Statute 287.087.

**8.25. Public Entity Crimes**

A person or affiliate who has been placed on the convicted vendor list following a conviction for public entity crime may not submit a Proposal on a contract to provide any goods or services to a public entity, may not submit a Proposal on a contract with a public entity for the construction or repair of a public building or public work, may not submit Proposals on leases of real property to a public entity, may not be awarded or perform work as a

contractor, supplier, subcontractor, or consultant under a contract with any public entity, and may not transact business with any public entity in excess of the threshold amount provided in Florida Statute, Section 287.017, for CATEGORY TWO for a period of 36 months from the date of being placed on the convicted vendor list.

#### **8.26. Patent Fees, Royalties, And Licenses**

If the selected Proposer requires or desires to use any design, trademark, device, material, or process covered by letters of patent or copyright. In that case, the selected Proposer and his surety shall indemnify and hold harmless the City from any and all claims for infringement because of the use of any such patented design, device, trademark, copyright, material, or process in connection with the work agreed to be performed and shall indemnify the City from any cost, expense, royalty or damage which the City may be obligated to pay because of any infringement at any time during or after completion of the work.

#### **8.27. Price Adjustments**

Prices offered shall remain firm throughout the Agreement. A request for a price adjustment, with proper documentation justifying the adjustment, may be submitted in writing thirty (30) calendar days before the first-anniversary date of the Agreement. Price adjustment requests shall be evaluated on an annual basis after that. Rate adjustments must have written approval from the City before invoicing. Any rate adjustment invoiced without the City's written consent shall not be paid, and the invoice will be returned to the Awardee for correction.

The Director, Procurement and Contracts, may, in the Director's sole discretion, on behalf of the City, equitably adjust pricing if the pricing or availability of services, coverage, or administrative services is adversely affected by extreme and unforeseen volatility in the marketplace. Consideration for any pricing adjustment shall require the vendor to provide irrefutable evidence that **ALL** the following circumstances exist:

- i. The volatility is due to causes wholly beyond the vendor's control and
- ii. The volatility affects the marketplace or industry, not just the vendor's source of supply, and
- iii. The effect on pricing or availability of services, coverage, or administrative services is substantial, and
- iv. The volatility so affects the vendor that continued performance of the Agreement would result in a substantial loss.

Note: The Director of Procurement and Contracts must confirm any pricing adjustment in writing.

**PRICE REDUCTIONS:** Awarded vendors may offer to the City, at any time during the Agreement period, additional discounts from the prices offered in this Solicitation and invoice less than the prices offered in their submitted bid. If, from the date of bid opening, the Awardee either bids the same products at a lower price than offered to the City or reduces the price of the offered coverage or services to another entity, the lowest of these reduced prices shall be extended to the City.

#### **8.28. Invoicing/Payment**

All invoices should be sent to the City of Pompano Beach, Accounts Payable, P.O. Drawer 1300, Pompano Beach, Florida, 33061. In accordance with Florida Statutes, Chapter 26, payment will be made within 45 days after receipt of a proper invoice.

#### **8.29. Taxes**

The City of Pompano Beach, Florida, does not pay Federal Excise or State taxes on purchases of tangible personal property. The sales tax exemption number is available upon request. This exemption does not apply to purchases of tangible property made by contractors who use tangible personal property in the performance of contracts for the improvement of real property owned by the City of Pompano Beach.

#### **8.30. Force Majeure**

Neither party shall be obligated to perform any duty, requirement, or obligation under this RFP if the City has determined that such performance is prevented by fire, hurricane, earthquake, explosion, war, sabotage, accident, flood, acts of God, strikes, or other labor disputes, riot or civil commotions, epidemics, pandemics,

government regulations, and the issuance or extension of existing government orders of the United States, the State of Florida, or local county and municipal governing bodies, or because of any other matter or condition beyond the control of either party and which cannot be overcome by reasonable diligence and without unusual expense (“Force Majeure”). In no event shall lack of funds on the part of either party be deemed Force Majeure.

**8.31. Public Records**

The City is a public agency subject to Section 119, Florida Statutes. The Contractor shall comply with Florida’s Public Records Law, as amended. Specifically, the Contractor shall:

- a. Keep and maintain public records required by the City in order to perform the service;
- b. Upon request from the City’s custodian of public records, provide the City with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in Section 119, Florida Statutes, or as otherwise provided by law;
- c. Ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of the agreement/contract term and following completion of the agreement/contract if the Contractor does not transfer the records to the City; and
- d. Upon completion of the agreement/contract, transfer, at no cost to the City, all public records in possession of the Contractor, or keep and maintain public records required by the City to perform the service. If the Contractor transfers all public records to the City upon completion of the agreement/contract, the Contractor shall destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. If the Contractor keeps and maintains public records upon completion of the agreement/contract, the Contractor shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to the City upon request from the City’s custodian of public records in a format compatible with the City’s information technology systems.

Failure of the Contractor to provide the above-described public records to the City within a reasonable time may subject the Contractor to penalties under Section 119.10, Florida Statutes, as amended.

**8.32. Public Records Custodian:**

If the awarded Proposer has questions regarding the application of Chapter 119, Florida Statutes, to the awarded Proposer’s duty to provide public records relating to the agreement/contract, contact the custodian of public records at:

**CITY CLERK  
100 W. Atlantic Blvd., Suite 253,  
Pompano Beach, Florida 33060  
(954) 786-4611  
RecordsCustodian@copbfl.com**

## **9. ADDENDA**

The issuance of a written addendum or posting of an answer in response to a question submitted using the Questions feature in the eBid System is the only official method by which interpretation, clarification, or additional information can be provided. If any addenda are issued for this solicitation, they will be posted via the eBid System. The Proposer must obtain all Addendum/Addenda posted for this RFP in the eBid System before submitting a response to this RFP.

## **10. ATTACHMENTS AND EXHIBITS**

- Insurance Requirements
- T1\_T2\_Form
- Local Business Program Forms
- BlueCare HMO 55 - Medical Plan Design
- BlueChoice PPO 0727 - Medical Plan Design
- BlueChoice PPO 0727 (Retirees O65)
- Questionnaires
- Response Forms - Self-Funded Medical
- AOR
- Benefit Census Report
- Medical Plan Summaries
- BlueCare HMO Plan 55
- BlueCare HMO Plan 55 COC
- BlueChoice PPO Plan 0727 SBC
- BlueChoice PPO Plan 0727 COC
- Claims Report – Oct 2021-Sept 2022
- Claims Report – Oct 22-Sept 2023
- Claims Report – Oct 2023-Nov 2024
- Claims Report – Oct 2024 – Sept 2025
- Medical Disruption Report
- Sample Service Agreement



City of Pompano Beach  
Procurement and Contracts Department  
1010 N.E. 3rd Avenue  
Pompano Beach, Florida, 33060

**April 16, 2026**

**ADDENDUM #1**

**RFP26-035 Employee Medical Benefits Program (Fully Insured and Self-Funded Options)**

To Whom It May Concern,

Addendum #1 has been posted on the City's eBid System at the following link:  
<https://pompanobeachfl.ionwave.net/PublicDetail.aspx?bidID=1114&SourceType=1>.

Proposers are reminded to acknowledge receipt of this Addendum by completing the Addendum Attribute in the Attributes tab within the eBid System.

The City is issuing this Addendum to extend the proposal due date from April 22, 2026, to April 27, 2026. Additionally, a subsequent addendum with additional information will be issued.

The remainder of the solicitation is unchanged at this time.

Sincerely,

Eric Seifer,  
Purchasing Supervisor

cc: website



City of Pompano Beach  
Procurement and Contracts Department  
1010 N.E. 3rd Avenue  
Pompano Beach, Florida, 33060

**April 21, 2026**

**ADDENDUM #2**

**RFP26-035 Employee Medical Benefits Program (Fully Insured and Self-Funded Options)**

To Whom It May Concern,

Addendum #2 has been posted on the City's eBid System at the following link:  
<https://pompanobeachfl.ionwave.net/PublicDetail.aspx?bidID=1114&SourceType=1>.

Proposers are reminded to acknowledge receipt of this Addendum by completing the Addendum Attribute in the Attributes tab within the eBid System.

The City is issuing this Addendum to provide additional information and attachments in response to proposer questions. The following documents have been added to the solicitation in the Attachments tab of the eBid System:

- Rx Claims Report (March 2024 – February 2026)
- Top Drugs – Paid (January 2025 – December 2025)
- Monthly Claims Report (January 2025 – December 2025)
- Monthly Claims Report (March 2025 – February 2026)
- Pharmacy Network Listing

This Addendum provides information that may impact proposal preparation.

Proposers are responsible for reviewing all newly posted documents and incorporating this information into their proposals as applicable.

The remainder of the solicitation is unchanged at this time.

Sincerely,

Eric Seifer,  
Purchasing Supervisor

cc: website



City of Pompano Beach  
Procurement and Contracts Department  
1010 N.E. 3rd Avenue  
Pompano Beach, Florida, 33060

**April 22, 2026**

**ADDENDUM #3**

**RFP26-035 Employee Medical Benefits Program (Fully Insured and Self-Funded Options)**

To Whom It May Concern,

Addendum #3 has been posted on the City's eBid System at the following link:  
<https://pompanobeachfl.ionwave.net/PublicDetail.aspx?bidID=1114&SourceType=1>.

Proposers are reminded to acknowledge receipt of this Addendum by completing the Addendum Attribute in the Attributes tab within the eBid System.

The City is issuing this Addendum to provide additional information and attachments in response to proposer questions. The following documents have been added to the solicitation in the Attachments tab of the eBid System:

- Aflac Critical Care Protection Plan Brochure
- Aflac Accident Advantage Plan Brochure

These documents are being provided for informational purposes and may impact proposal preparation.

Proposers are responsible for reviewing all newly posted documents and incorporating this information into their proposals as applicable.

The remainder of the solicitation is unchanged at this time.

Sincerely,

Eric Seifer,  
Purchasing Supervisor

cc: website

# Online Questions & Answers

## Event Information

Number: RFP26-035 Addendum 3  
Title: Employee Medical Benefits Program ( Fully Insured and Self-Funded Options)  
Type: Request for Proposals  
Issue Date: 3/19/2026  
Question Deadline: 4/21/2026 05:00 PM (ET)  
Response Deadline: 4/27/2026 02:00 PM (ET)  
Notes: The City of Pompano Beach is soliciting experienced and qualified firms that demonstrate the highest level of ability to provide the following lines of coverage:

- Medical Insurance with the following funding arrangement:
  - o Fully-Insured
  - o Self-Insured
  - o Medical Insurance (Fully Insured and Self-Funded)
  - o Pharmacy Benefit Management Services (if applicable)
  - o Stop Loss Insurance (if applicable)

The Cone of Silence shall take effect once this solicitation is released to the General Public. Respondents to this solicitation or persons acting on their behalf may not contact, between the release of the solicitation and the end of the 72 hours following the agency posting the notice of intended award, excluding Saturdays, Sundays, and state holidays, any employee or officer of the executive or legislative branch concerning any aspect of this solicitation, except in writing to the procurement officer or as provided in the solicitation documents. Violation of this provision may be grounds for rejecting a response.” (F.S 287.057 (25)).

Proposers must be registered on the City’s eBid System in order to view the solicitation documents and respond to this Solicitation. The complete solicitation document can be downloaded from the eBid System as a PDF at <https://www.pompanobeachfl.ionwave.net>. The City is not responsible for the accuracy or completeness of any documentation the proposer receives from any source other than the eBid System. The proposer is solely responsible for downloading all required documents. A list of proposers will be read aloud in a public forum. To attend the virtual public meeting, go to <https://www.pompanobeachfl.gov/pages/meetings> to find the Zoom link.

Carefully read all portions of the RFQ document to ensure the Proposer's bid fully complies with all requirements.

Procurement and Contracts Department  
City of Pompano Beach, Florida.

**No questions published**

# Public Questions & Answers

## Event Information

Number: RFP26-035 Addendum 3  
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Carefully read all portions of the RFQ document to ensure the Proposer's bid fully complies with all requirements.

Procurement and Contracts Department  
City of Pompano Beach, Florida.

## Published Questions

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Question: • Is the City seeking an exclusive specialty pharmacy model, or an open specialty network?

Answer: Open specialty network

Asked: 4/20/2026 03:41 PM (ET)

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Question: • Does the City have a stated preference for low WAC pricing vs. traditional rebate driven models, assuming full transparency?

Answer: low WAC pricing

Asked: 4/20/2026 03:40 PM (ET)

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Question: • Should bidders assume a standard ACA preventive drug list only, or is an expanded preventive list desired (either by default or as an option)?

Answer: An expanded preventive list is desired

Asked: 4/20/2026 03:40 PM (ET)

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Question: • Does the City have a preference for open vs. exclusionary formulary design, or should bidders propose their recommended approach? • What is the current tier structure of the formulary(ies)?

Answer: Please provide your recommended approach, and the City will be open to further discussion on generic, formulary, non-formulary, and mail-order options.

Asked: 4/20/2026 03:40 PM (ET)

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Question: • Is the City supportive of a biosimilar first strategy, including potential originator exclusion where clinically appropriate?

Answer: Open to discussion.

Asked: 4/20/2026 03:40 PM (ET)

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Question: • Should bidders assume weight loss GLP 1 medications are excluded by default, or is coverage under consideration?

Answer: Coverage is under consideration.

Asked: 4/20/2026 03:39 PM (ET)

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Question: Please share the current Accident/Critical Illness plan details, if available.

Answer: Attachments #6 & #7.

Asked: 4/20/2026 09:46 AM (ET)

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Question: Please share any employee/member feedback the City has received around cost, access, network, et al.

Answer: Per employees:

- Family coverage is high per employee for both HMO and PPO plans, affecting their cost-sharing.
- Access to regional hospitals and care in relation to Pompano Beach.
- A few have inquired about weight loss Rx coverage

Asked: 4/20/2026 09:46 AM (ET)

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Question: Please share any current EAP/point solutions/wellness benefits provided by the incumbent.

Answer: \$100,000

Asked: 4/20/2026 09:45 AM (ET)

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Question: ASO: Please share what ISL the City would like on the plan.

Answer: 12/12 and 12/1; \$200K, \$225k, \$250K; 120% & 125%; Unlimited Include TLO and no lasers.

Asked: 4/20/2026 09:45 AM (ET)

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Question: Please provide more recent claims data, and updated HCC and Top Rx/drug utilization data to match updated claims.

Answer: Attachments #3 & #4.

Asked: 4/20/2026 09:44 AM (ET)

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Question: The BlueChoice PPO 0727 (Retirees O65) & BlueChoice PPO 0727 – Medical Plan Designs show member cost-sharing for In-Network Inpatient Hospital at \$100 PAD + CYD + 20%. Please clarify the meaning of "PAD".

Answer: Per Admission Deductible (PAD).

Asked: 4/9/2026 03:15 PM (ET)

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Question: The BlueChoice PPO 0727 (Retirees O65) & BlueChoice PPO 0727 – Medical Plan Designs show member cost-sharing for Chiropractic services at \$35 (Physician Office)/(Outpatient) CYD +20%. What type of setting does "Outpatient" refer to, i.e., how does this differ from physician office?

Answer: Outpatient refers to a rehabilitation Center

Asked: 4/9/2026 03:15 PM (ET)

---

Question: The BlueCare HMO 55 - Medical Plan Design shows member cost-sharing for Inpatient Hospital at \$150/Day – Max \$450. Does the \$450 max apply regardless of length of stay?

Answer: \$450 Max is per admission.

Asked: 4/9/2026 03:15 PM (ET)

---

Question: The BlueCare HMO 55 - Medical Plan Design shows member cost-sharing for Chiropractic services at \$35 (Physician Office)/\$20 (Outpatient). What type of setting does "Outpatient" refer to, i.e., how does this differ from physician office?

Answer: Outpatient refers to a rehabilitation Center

Asked: 4/9/2026 03:15 PM (ET)

---

Question: Combined vs. Stand-Alone Pricing Options - Would the City like Medical + Rx combined and stand-alone pricing options, each with applicable guarantees and discount logic?

Answer: Combined.

Asked: 4/9/2026 03:14 PM (ET)

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Question: Does the City require all lines of coverage to be quoted, or may proposers submit Medical Fully Insured / Medical Self-Funded / Stop Loss / Rx only?

Answer: Medical Fully Insured / Medical Self-Funded / Stop Loss / Rx only.

Asked: 4/9/2026 03:14 PM (ET)

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Question: RFP 6.22 & 6.23. Is it the City's expectation that the Local Business Program Forms and the T1 / T2 Form be included in both 6.22 and 6.23?

Answer: Sections 6.22 and 6.23 are intended to work together.

Section 6.22 provides specific requirements and documentation related to the Local Business Program, including any additional supporting documentation required for proposers claiming Tier 1 or Tier 2 status.

Section 6.23 is intended to broadly capture all required City forms, including the Local Business Program forms and the Tier 1 / Tier 2 Compliance Form.

Proposers may include the Local Business Program forms and Tier 1 / Tier 2 Compliance Form in either section, or both, as long as all required forms and supporting documentation are included in the proposal.

Failure to include the required Local Business Program forms (Exhibits A–D, as applicable) may result in the proposal being deemed non-responsive, as outlined in the solicitation.

Asked: 4/9/2026 03:14 PM (ET)

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Question: RFP 6.13. Questionnaire and Fact Sheet. Provide responses to all items listed in the City's Questionnaire and Fact Sheet. Please provide the Fact Sheet.

Answer: The reference to "Questionnaires and Fact Sheet" in Section 6.13 is intended to encompass all required response forms, questionnaires, and supporting documents that proposers must complete and submit as part of their proposal.

This includes, but is not limited to:

The Questionnaire – Medical and related sections  
Response Forms – Self-Funded Medical  
Medical Plan Design and rate forms (e.g., PPO, HMO, and alternative plan designs)  
Local Business Program forms (Exhibits A–D)  
Tier 1 / Tier 2 Compliance Form

There is no separate standalone "fact sheet" document. Proposers are expected to complete all applicable forms provided in the Attachments tab and include them with their submission.

Asked: 4/9/2026 03:14 PM (ET)

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Question: RFP 6. Proposal Requirements & Evaluation Criteria. Please confirm it is acceptable to add an "Appendices" section as the last tab of our submission, so that we can incorporate additional items being requested.

Answer: Yes

Asked: 4/9/2026 03:13 PM (ET)

---

Question: What is the current structure of the wellness program, and how much wellness funding does the incumbent carrier provide?

Answer: Formal Behavior Health Access Program  
2 onsite employee gyms;  
Contracted Onsite trainer available;  
Mental health walk;  
Health Fair;  
Wellable app;  
Angio screening and other types of events;  
Bio screenings; and  
\$100,000

Asked: 4/9/2026 03:13 PM (ET)

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Question: Please supply Stop Loss contract terms.

Answer: "a.12/12 and 12/15  
b.\$200K, \$225k, \$250K  
c. 120% & 125%  
d. Unlimited  
e. Include TLO  
f. Yes no lasers"

Asked: 4/9/2026 03:13 PM (ET)

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Question: Please supply Large Claims data with concurrent experience and paid period (not including prior paid period).

Answer: Attachments #3 & #4

Asked: 4/9/2026 03:12 PM (ET)

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Question: Questionnaire - Medical #3. Please confirm whether all SF and FI data should be included when calculating discounts.

Answer: Please provide the most recent discounts available (2025). Include locations in Miami-Dade, Broward, and Palm Beach Counties.

Asked: 4/9/2026 03:11 PM (ET)

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Question: Questionnaire - Medical #3. Please confirm whether the discounts should be based on 2025 results.

Answer: Yes

Asked: 4/9/2026 03:10 PM (ET)

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Question: Questionnaire - Medical #3. The request does not include outpatient (OP) hospital or OP service discounts. Please confirm whether these should be included.

Answer: Yes

Asked: 4/9/2026 03:10 PM (ET)

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Question: Questionnaire - Medical #3. Please confirm average discounts for the geographic area represented in the employee/member census. Please confirm the four geographic locations you would like us to use. The census reflects participation throughout the state of Florida rather than being concentrated in four specific metropolitan areas.

Answer: Please provide the most recent discounts available (2025). Include locations in Miami-Dade, Broward, and Palm Beach Counties.

Asked: 4/9/2026 03:10 PM (ET)

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Question: Questionnaire - Medical #2. For the GeoAccess requirement of 2 PCPS & Pediatricians within 10 miles, please clarify the City is requesting Adult PCPs and Pediatricians combined.

Answer: Combined and Separate.

Asked: 4/9/2026 03:09 PM (ET)

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Question: Please provide the fact sheet listed under, 6.13 Questionnaires and Fact Sheet, or the name of the document referenced under the Attachments tab.

Answer: The reference to "Questionnaires and Fact Sheet" in Section 6.13 is intended to encompass all required response forms, questionnaires, and supporting documents that proposers must complete and submit as part of their proposal.

This includes, but is not limited to:

The Questionnaire – Medical and related sections  
Response Forms – Self-Funded Medical  
Medical Plan Design and rate forms (e.g., PPO, HMO, and alternative plan designs)  
Local Business Program forms (Exhibits A–D)  
Tier 1 / Tier 2 Compliance Form

There is no separate standalone "fact sheet" document. Proposers are expected to complete all applicable forms provided in the Attachments tab and include them with their submission.

Asked: 4/9/2026 09:07 AM (ET)

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Question: How should the 20% of contract be calculated on the Fully Insured/Guaranteed Cost product?

Answer: In accordance with the City's Local Business Program Ordinance and the requirements outlined in the solicitation, participation is evaluated based on either meeting the applicable Tier 1 or Tier 2 residency requirements or demonstrating the required level of local vendor participation as a percentage of the total contract value.

Proposers should calculate any local participation based on the total contract value and clearly document how the requirement is met.

If a proposer does not meet the Tier 1 or Tier 2 criteria or the applicable participation threshold, no points will be awarded under the Local Business Program evaluation criterion.

Asked: 4/7/2026 03:35 PM (ET)

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Question: Who are the current local business suppliers and/or types of services that the incumbent is utilizing?

Answer: The City does not have the incumbent's subcontractor or local supplier information readily available.

Proposers are encouraged to independently identify and engage qualified local vendors. A directory of local businesses is available on the City's website at the following link:  
<https://www.pompanobeachfl.gov/government/code-compliance/business-tax-receipt-division>

Proposers may navigate to the "Shop Pompano" section and the Pompano Beach Business Directory to locate local businesses by category.

Asked: 4/7/2026 03:35 PM (ET)

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Question: If the bidder has a permanent Broward County Office AND 15% of the population is Pompano Beach residents, is the 20% Local Businesses Supplier utilization still required?

Answer: No. If a proposer qualifies as a Tier 2 Local Vendor based on maintaining a permanent place of business within Broward County and meeting the required percentage of Pompano Beach resident employees, they are not additionally required to meet the subcontracting participation threshold to qualify for Tier 2 status.

The ordinance provides alternative methods to qualify for Tier 2 status, and meeting the employee residency requirement independently satisfies that qualification.

Proposers claiming Tier 2 status under the employee residency requirement must provide documentation sufficient to verify that at least fifteen percent (15%) of their local office staff are Pompano Beach residents. Such documentation may include employee residency certifications, payroll records, or other supporting materials acceptable to the City.

All proposers must still comply with the Local Business Program submittal requirements outlined in the solicitation.

Asked: 4/7/2026 03:34 PM (ET)

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Question: Can you confirm if retiree rates are needed for all plans or for only plan 0727?

Answer: Only Plan 0727

Asked: 4/7/2026 12:06 PM (ET)

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Question: What rate tiers should carriers quote for the fully insured response (2 tier, 3 tier or 4 tiers)?

Answer: 2-tier and 4-tier.

Asked: 4/7/2026 12:05 PM (ET)

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Question: Can we get an updated claims file?

Answer: Attachments #3 & #4.

Asked: 4/7/2026 12:05 PM (ET)

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Question: We received the Response Form for the Self Insured but do not see a response form for Fully Insured. How would you like for vendors to provide for fully insured?

Answer: Response forms are included in BlueCare HMO 55 - Medical plan Design and BlueChoice PPO 0727-Medical plan designs.

Asked: 4/7/2026 11:52 AM (ET)

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Question: If a carrier does not qualify for a Tier 1 or Tier 2 prime vendor, are there any points or goals associated with subcontracting with Tier 1 or Tier 2 local vendors?

Answer: No. If the prime proposer does not qualify as a Tier 1 or Tier 2 Local Vendor, the proposer is not eligible to receive Local Business Program preference points.

However, all proposers are still required to comply with the Local Business Program submittal requirements outlined in the solicitation. This includes completing and submitting the required forms (Exhibits A through D, as applicable), even if the proposer is not claiming Tier 1 or Tier 2 participation. In such cases, the forms must be submitted and clearly marked "Not Applicable."

Additionally, proposers listing any local subcontractors or subconsultants must provide valid City of Pompano Beach Business Tax Receipts for each entity identified. Failure to provide the required documentation may result in the loss of associated points or the proposal being deemed non-responsive.

Asked: 4/3/2026 10:07 AM (ET)

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Question: Would it be possible to get Rx Utilization data?

Answer: Attachment #1.

Asked: 3/30/2026 05:10 PM (ET)

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Question: Please provide BCBS Paid Claims on a Rolling 12 Month Basis from (1/1/2025 – 12/31/2025) along with a Large Claims with Diagnosis Report on a Paid Basis for the same experience period (1/1/2025 -12/31/2025).

Answer: Attachment #3

Asked: 3/30/2026 11:17 AM (ET)

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Question: Please provide an updated aggregate monthly claims report for the current policy period for claims paid from 10/2025 through 2/2026 (assuming ASL is requested)

Answer: Attachment #4

Asked: 3/26/2026 11:21 AM (ET)

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Question: Please provide an updated high cost claims report for the current policy period for claims paid from 10/2025 through 02/2026

Answer: Attachment #4

Asked: 3/26/2026 11:21 AM (ET)

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Question: Please specify the stop loss coverage requested a. Contract Basis: b. Individual Stop Loss Deductible Level: c. Aggregate Stop Loss % Corridor: d. Aggregating Specific Deductible: e. TLO coverage: f. Renewal Risk Cap w/ No New Lasers?

Answer: a.12/12 and 12/15  
b.\$200K, \$225k, \$250K  
c. 120% & 125%  
d. Unlimited  
e. Include TLO  
f. Yes no lasers

Asked: 3/26/2026 11:20 AM (ET)

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Question: Please confirm if there are any expected changes this would group would like to make to weight loss Rx coverage or weight management programs.

Answer: No, but open to reviewing

Asked: 3/26/2026 11:20 AM (ET)

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Question: Please include Rx claim files in excel format with the following fields: o Drug NDC o Pharmacy NABP or NPI number o Retail/MOD Indicator o Dispense Date o Quantity Dispensed o Days Supply

Answer: Attachment #1

Asked: 3/26/2026 11:16 AM (ET)

---

Question: What is the ISL level and contract period?

Answer: a.12/12 and 12/15  
b.\$200K, \$225k, \$250K  
c. 120% & 125%  
d. Unlimited  
e. Include TLO  
f. Yes no lasers

Asked: 3/24/2026 07:25 PM (ET)

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Question: What retail pharmacies for 30 day and 90 day are participating under the pharmacy benefit?

Answer: CVS, Walgreens, Publix and Walmart.

Asked: 3/24/2026 07:16 PM (ET)

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## **Exhibit “B” – Cover Page**

1. Contractor’s Response
2. **Proposal**
3. Sunbiz Documentation
4. Local Business Forms
5. T1-21 Form
6. Questionnaire



## RFP26-035 Addendum 3

**Aetna**

### **Supplier Response**

#### **Event Information**

Number: RFP26-035 Addendum 3  
Title: Employee Medical Benefits Program ( Fully Insured and Self-Funded Options)  
Type: Request for Proposals  
Issue Date: 3/19/2026  
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(F.S 287.057 (25)).

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Carefully read all portions of the RFQ document to ensure the Proposer's bid fully complies with all requirements.

Procurement and Contracts Department  
City of Pompano Beach, Florida.

### **Contact Information**

Contact: Eric Seifer  
Address: Procurement & Contracts  
1010 NE 3rd Avenue  
Pompano Beach, FL 33060  
Phone: 954 (786) 4166  
Email: [eric.seifer@copbfl.com](mailto:eric.seifer@copbfl.com)

## Aetna Information

Address: 1340 Concord Terrace  
Sunrise, FL 33323  
Phone: (954) 397-9053

By submitting this Response I affirm I have received, read and agree to the all terms and conditions as set forth herein. I hereby recognize and agree that upon execution by an authorized officer of the City of Pompano Beach, this Response, together with all documents prepared by or on behalf of the City of Pompano Beach for this solicitation, and the resulting Contract shall become a binding agreement between the parties for the products and services to be provided in accordance with the terms and conditions set forth herein. I further affirm that all information and documentation contained within this response to be true and correct, and that I have the legal authority to submit this response on behalf of the named Supplier (Offeror).

Mark Sternat

*Signature*

Submitted at 4/27/2026 01:22:45 PM (ET)

SternatM@aetna.com

*Email*

## Requested Attachments

### Tier 1/ Tier 2 Local Business Form

T1\_T2\_Form.pdf

To comply with the City's Local Business Program as a Tier-1 or Tier-2 vendor, you must complete the Tier 1/ Tier 2 Local Business form from the attachments tab and upload it here.

### Local Business Program Forms

Local Business Program  
Forms.pdf

Local Business Program Forms from the attachments tab are to be completed and uploaded to this tab.

### Proposal

Aetna Response to City of  
Pompano Beach.zip

Electronic version of proposal must be uploaded to the Response Attachments tab. The file size for uploads is limited to 250 MB. If the file size exceeds 250 MB the response must be split and uploaded as two (2) separate files.

### Questionnaires

2. Questionnaires.docx

## Bid Attributes

### 1 Terms & Conditions

Check the box indicating you agree to the terms and conditions of this solicitation.

Agree

### 2 Acknowledgement of Addenda

Check this box to acknowledge that you have reviewed all addenda issued for this solicitation.

Yes

### 3 Local Business Participation Percentage

If you have indicated local business participation on the Local Business Participation Form Exhibit A enter the percentage of the contract that will be performed by local Pompano Beach businesses.

**4 Extension of prices, terms and conditions to other governmental entities**

If awarded the contract resulting from this bid, will your company agree to extend the same prices, terms and conditions to other governmental entities? (Note -- Optional, agreement not required for contract award.) All Purchases made by other governmental entities shall be understood to be transactions between that entity and the awarded vendor; the City of Pompano Beach shall not be a party to or be responsible for any such purchases. Indicate by selecting yes or no from the drop down menu.

Yes

**5 Vendor Certification Regarding Scrutinized Companies Lists (Any Dollar Amount)**

Section 215.4725, Florida Statutes, prohibits agencies from contracting (at any dollar amount) with companies on the Scrutinized Companies that Boycott Israel List, or with companies that are engaged in a boycott of Israel. As the person authorized to electronically sign on behalf of Respondent, I hereby certify by selecting the box below that the company responding to this solicitation is not listed on the Scrutinized Companies that Boycott Israel List. I also certify that the company responding to this solicitation is not participating in a boycott of Israel, and is not engaged in business operations in Syria or Cuba. I understand that pursuant to sections 287.135 and 215.4725, Florida Statutes, the submission of a false certification may subject company to civil penalties, attorney's fees, and/or costs. Select yes for Agree, No for disagree on the drop down menu.

Yes

**6 Drug-Free Workplace**

STATEMENT UNDER SECTION 287.087, FLORIDA STATUTES ON DRUG-FREE WORKPLACE

**REQUESTED INFORMATION BELOW IS ON THE ATTRIBUTES TAB FOR THE RFP IN THE EBID SYSTEM. PROVIDE THIS INFORMATION ELECTRONICALLY.**

Preference must be given to Contractors submitting certification with their bid or proposal, certifying they have a drug-free workplace in accordance with Section 287.087, Florida Statutes. This requirement affects all public entities of the State and becomes effective January 1, 1991.

Preference shall be given to businesses with drug-free workplace programs. Whenever two or more bids which are equal with respect to price, quality and service are received by the State or by any political subdivision for the procurement of commodities or contractual services, a bid received from a business that certifies that it has implemented a drug-free workplace program shall be given preference in the award process. Established procedures for processing tie bids will be followed if none of the tied vendors have a drug-free workplace program. In order to have a drug-free workplace program, a business shall:

- (1) Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the workplace and specifying the actions that will be taken against employees for violations of such prohibition.
- (2) Inform employees about the dangers of drug abuse in the workplace, the business's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations.
- (3) Give each employee engaged in providing the commodities or contractual services that are under bid, a copy of the statement specified in subsection (1).
- (4) In the statement specified in subsection (1) notify the employees that as a condition of working on the commodities or contractual services that are under bid, the employee will abide by the terms of the statement and will notify the employer of any conviction of, or plea of guilty or nolo contendere to, any violation of Chapter 893 or of any controlled substance law of the United States or any state, for a violation occurring in the workplace, no later than five (5) days after such conviction.
- (5) Impose a sanction on, or require the satisfactory participation in, a drug abuse assistance or rehabilitation program if such is available in the employee's community, by an employee who is so convicted.
- (6) Make a good faith effort to continue to maintain a drug-free workplace through implementation of this section.

As the person authorized to sign this statement, I certify that his company/firm complies with the above requirements.

By choosing YES, I hereby certify that the company/firm complies with all the above requirements

Yes

**7 Conflict of Interest**

For purposes of determining any possible conflict of interest, all bidders must disclose if any City of Pompano Beach employee is also an owner, corporate officer, or employee of their business. Indicate either "Yes" (a City employee is also associated with your business), or "No". (Note: If answer is "Yes", you must file a statement with the Supervisor of Elections, pursuant to Florida Statutes 112.313.)Indicate yes or no below with the drop down menu.

No

**8 City of Pompano Beach Local Business**

Is your company a Local Business located within the City of Pompano Beach City Limits as required by the Local Business Program? (A copy of your current City of Pompano Beach Business Tax Receipt may be requested.)Indicate yes or no from drop-down menu.

Yes



[Department of State](#) / [Division of Corporations](#) / [Search Records](#) / [Search by Entity Name](#) /

## Detail by Entity Name

Foreign Profit Corporation

AETNA LIFE INSURANCE COMPANY

### Filing Information

<b>Document Number</b>	800878
<b>FEI/EIN Number</b>	06-6033492
<b>Date Filed</b>	08/29/1916
<b>State</b>	CT
<b>Status</b>	ACTIVE
<b>Last Event</b>	REINSTATEMENT
<b>Event Date Filed</b>	10/22/2001

### Principal Address

151 Farmington Avenue  
RW61  
Hartford, CT 06156

Changed: 02/19/2026

### Mailing Address

151 Farmington Avenue  
RW61  
Hartford, CT 06156

Changed: 02/19/2026

### Registered Agent Name & Address

CHIEF FINANCIAL OFFICER  
200 E. GAINES ST  
TALLAHASSEE, FL 32399-0000

Name Changed: 03/17/2003

Address Changed: 04/10/2014

### Officer/Director Detail

#### **Name & Address**

Title Treasurer

Smith, Tracy Louise  
151 Farmington Avenue  
RW61  
Hartford, CT 06156

Title Director

Guerraz, Katerina  
151 Farmington Avenue  
RW61  
Hartford, CT 06156

Title Director

Smith, Tracy Louise  
151 Farmington Avenue  
RW61  
Hartford, CT 06156

Title VP

Mike, David Robert  
151 Farmington Avenue  
RW61  
Hartford, CT 06156

Title VP

Lee, Edward Chung-I  
151 Farmington Avenue  
RW61  
Hartford, CT 06156

Title Secretary

Lee, Edward Chung-I  
151 Farmington Avenue  
RW61  
Hartford, CT 06156

Title Director

Oades, Peter Robert  
151 Farmington Avenue  
RW61  
Hartford, CT 06156

Title VP

Drzazgowski, Jeffrey James  
151 Farmington Avenue  
RW61

Hartford, CT 06156

Title VP

Bauer, Craig E.  
151 Farmington Avenue  
RW61  
Hartford, CT 06156

Title VP

Lask, Russell J.  
151 Farmington Avenue  
RW61  
Hartford, CT 06156

Title VP

Lessard, Rhonda  
151 Farmington Avenue  
RW61  
Hartford, CT 06156

Title VP

Moffatt, Thomas S.  
151 Farmington Avenue  
RW61  
Hartford, CT 06156

Title VP

Shimanek, Anna E.  
151 Farmington Avenue  
RW61  
Hartford, CT 06156

Title VP

Campbell, Christopher Robert  
151 Farmington Avenue  
RW61  
Hartford, CT 06156

Title VP

Cooper, Mary L.  
151 Farmington Avenue  
RW61  
Hartford, CT 06156

Title VP

Smith, Tracy Louise  
 151 Farmington Avenue  
 RW61  
 Hartford, CT 06156

### Annual Reports

<b>Report Year</b>	<b>Filed Date</b>
2024	04/24/2024
2025	04/23/2025
2026	02/19/2026

### Document Images

<a href="#">02/19/2026 -- ANNUAL REPORT</a>	<a href="#">View image in PDF format</a>
<a href="#">04/23/2025 -- ANNUAL REPORT</a>	<a href="#">View image in PDF format</a>
<a href="#">04/24/2024 -- ANNUAL REPORT</a>	<a href="#">View image in PDF format</a>
<a href="#">11/28/2023 -- AMENDED ANNUAL REPORT</a>	<a href="#">View image in PDF format</a>
<a href="#">04/22/2023 -- ANNUAL REPORT</a>	<a href="#">View image in PDF format</a>
<a href="#">01/27/2022 -- ANNUAL REPORT</a>	<a href="#">View image in PDF format</a>
<a href="#">04/12/2021 -- ANNUAL REPORT</a>	<a href="#">View image in PDF format</a>
<a href="#">05/24/2020 -- ANNUAL REPORT</a>	<a href="#">View image in PDF format</a>
<a href="#">03/25/2019 -- ANNUAL REPORT</a>	<a href="#">View image in PDF format</a>
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<a href="#">03/27/2013 -- ANNUAL REPORT</a>	<a href="#">View image in PDF format</a>
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<a href="#">04/27/1999 -- ANNUAL REPORT</a>	<a href="#">View image in PDF format</a>
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<a href="#">04/16/1997 -- ANNUAL REPORT</a>	<a href="#">View image in PDF format</a>
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<a href="#">04/04/1995 -- ANNUAL REPORT</a>	<a href="#">View image in PDF format</a>

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Florida Department of State, Division of Corporations

The following form is not applicable as we have claimed Tier 2 status that our firm has maintained a permanent place of business within Broward County and maintains a staffing level, within this local office, of at least 15% who are residents of the City of Pompano Beach.

LOCAL BUSINESS EXHIBIT "A"  
 CITY OF POMPANO BEACH, FLORIDA  
 LOCAL BUSINESS PARTICIPATION FORM

Solicitation Number & Title: RFP26-035 - Employee Medical Benefits Program (Fully Insured and Self-Funded Options)

Prime Contractor's Name: Aetna Life Insurance Company

<u>Name of Firm, Address</u>	<u>Contact Person, Telephone Number</u>	<u>Type of Work to be Performed/Material to be Purchased</u>	<u>Contract Amount or %</u>
Not applicable.	Not applicable.	Not applicable.	Not applicable.

LOCAL BUSINESS EXHIBIT "A"



LOCAL BUSINESS  
UNAVAILABILITY FORM

BID # RFP26-035

I, Not applicable.  
\_\_\_\_\_  
(Name and Title)

of Not applicable., certify that on the N/A day of

Not applicable., I invited the following LOCAL BUSINESSES to bid work items to be performed in the City of Pompano Beach:

Business Name, Address	Work Items Sought	Form of Bid Sought (i.e., Unit Price, Materials/Labor, Labor Only, etc.)
Not applicable.		

Said Local Businesses:

- Did not bid in response to the invitation
- Submitted a bid which was not the low responsible bid
- Other: Not applicable.

Name and Title: Not applicable.

Date: Not applicable.

Note: Attach additional documents as available.

LOCAL BUSINESS EXHIBIT "D"  
GOOD FAITH EFFORT REPORT  
LOCAL BUSINESS PARTICIPATION

BID # RFP26-035

1. What portions of the contract have you identified as Local Business opportunities?

Not applicable.

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2. Did you provide adequate information to identified Local Businesses? Please comment on how you provided this information.

Not applicable.

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3. Did you send written notices to Local Businesses?

Yes       No

If yes, please include copy of the notice and the list of individuals who were forwarded copies of the notices.

4. Did you advertise in local publications?

Yes       No

If yes, please attach copies of the ads, including name and dates of publication.

5. What type of efforts did you make to assist Local Businesses in contracting with you ?

Not applicable.

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7. List the Local Businesses you will utilize and subcontract amount.

Not applicable.

<hr/>	\$ <hr/>
<hr/>	\$ <hr/>
<hr/>	\$ <hr/>

8. Other comments:  Not applicable.

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LOCAL BUSINESS EXHIBIT "D" – Page 2

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## TIER 1/TIER 2 COMPLIANCE FORM

**IN ORDER FOR YOUR FIRM TO COMPLY WITH THE CITY'S LOCAL BUSINESS PROGRAM AS A TIER 1 OR TIER 2 VENDOR, BIDDERS MUST COMPLETE THE INFORMATION BELOW AND UPLOAD THE FORM TO THE RESPONSE ATTACHMENTS TAB IN THE EBID SYSTEM.**

### **TIER 1 LOCAL VENDOR**

My firm has maintained a permanent place of business within the city limits and maintains a staffing level, within this local office, of at least 10 % who are residents of the City of Pompano Beach.

And/Or

My firm has maintained a permanent place of business within the city limits and my submittal includes subcontracting commitments to Local Vendors Subcontractors for at least 10 % of the contract value.

Or

My firm does not qualify as a Tier 1 Vendor.

### **TIER 2 LOCAL VENDOR**

My firm has maintained a permanent place of business within Broward County and maintains a staffing level, within this local office, of at least 15% who are residents of the City of Pompano Beach

And/Or

My firm has maintained a permanent place of business within Broward County and my submittal includes subcontracting commitments to Local Vendors Subcontractors for at least 20% of the contract value.

Or

My firm does not qualify as a Tier 2 Vendor.

**I certify that the above information is true to the best of my knowledge.**

April 22, 2026  
(Date)

Aetna Life Insurance Company  
(Name of Firm)

BY: Mark Sternat   
(Name)

## Questionnaire – Medical

### 1. Please provide your proposed Benefit Summaries as part of your response.

Confirmed. Please see our Benefit Review Document and Plan Designs located within our Plan Design section of our proposal response.

### 2. Please provide a Medical Geo Access report that illustrates the number of:

- a. 1 Hospital within 10 miles
- b. 2 PCPs & Pediatricians within 10 miles
- c. 2 OBs/Gyns, within 10 miles
- d. 2 Specialists within 10 miles (excluding OBs/Gyns)
- e. 2 Urgent Care Centers within 10 miles

The report format should include a breakdown by employee city of residence, with the number of employees in that location and the number of providers servicing that location. The report should also include reporting on the number and location of employees who do not meet the above criteria.

Please see our Geo Access Reports located within the Network Information section of our proposal response.

### 3. Please confirm average discounts for the geographic area represented in the employee/member census as follows:

**CONFIDENTIAL**

Charge Type	Location#1	Location#2	Location#3	Location#4
Location	Miami/Broward County	Palm Beach	Tampa	Orlando
Doctors/Physicians	78.0%	67.8%	79.6%	65.7%
Urgent Care Centers	75.4%	67.7%	79.6%	66.0%
In-Patient Hospital	65.6%	62.3%	66.1%	62.2%

### 4. Please identify the proposed provider network.

For our fully insured plans, we are proposing our Open Access® Elect Choice® and Aetna Open Access® Managed Choice® plans. For our self-funded plans, we are proposing our Aetna Choice® POS II and Open Access Aetna Select<sup>SM</sup> plans. Provided below is a description of each of these plan offerings.

### **Open Access® Elect Choice® plan**

We are proposing our Open Access® Elect Choice® plan as a national solution. Our Open Access Elect Choice plan is an in-network only health plan which lets a network doctor guide our members' care. Members can visit any doctor in our national network and they don't need referrals. Although not required, we recommend that all of our members choose a primary care physician (PCP). Their PCP provides routine medical exams and gets to know each member and their medical history to direct their care. You can also design their plan so that the PCP cost share applies only to the member's chosen PCP or to any network PCP. PCP Choice is also a product feature available on the Open Access Elect Choice plan. If you elect this feature, the member must choose a PCP.

As of December 31, 2025, our national network has more than:

- 300,000 primary care doctors
- 1,762,000 specialists
- 6,100 hospitals
- 44,800 ancillary providers
- 488,999 behavioral health providers<sup>1</sup>
- 147,868 EAP providers<sup>2</sup>

<sup>1</sup> Data represents behavioral health providers in our PPO-based plans as of 1/1/2026.

<sup>2</sup> Data represents our EAP providers available nationally as of 1/1/2026.

### **Aetna Open Access® Managed Choice® plan**

We are proposing our Open Access® Managed Choice® plan as a national solution. Our Open Access Managed Choice plan lets our members visit any doctor they choose. Members don't need referrals and can visit both in-network and out-of-network providers. Their out-of-pocket costs may be higher when they see a doctor not in our network.

As of December 31, 2025, our national network has more than:

- 294,000 primary care doctors
- 1,739,000 specialists
- 6,000 hospitals

- 44,000 ancillary providers
- 488,999 behavioral health providers<sup>1</sup>
- 147,868 EAP providers<sup>2</sup>

Members may need to choose a primary care physician (PCP). Their PCP provides routine medical exams and gets to know each member and their medical history to direct their care. They also help members learn about and understand their health. Plus, members may even lower their costs by having a PCP.

Our Open Access Managed Choice plan also gives members access to our tools, tips, programs and services that help them find network doctors, estimate costs and make informed decisions.

<sup>1</sup> Data represents behavioral health providers in our PPO-based plans as of 1/1/2026.

<sup>2</sup> Data represents our EAP providers available nationally as of 1/1/2026.

### **Aetna Choice® POS II plan**

We are proposing our Choice POS II plan as a national solution. Our Choice POS II plan is a point-of-service (POS) plan which lets our members visit in-network and out-of-network doctors and hospitals. Members have the freedom to pick their doctors and they don't need referrals.

As of December 31, 2025, our national network has more than:

- 300,000 primary care doctors
- 1,768,000 specialists
- 6,200 hospitals
- 45,000 ancillary providers
- 488,999 behavioral health providers<sup>1</sup>
- 147,868 EAP providers<sup>2</sup>

Choice POS II uses our national network plus rural providers contracted through third-party vendors. Based on our internal analysis of your geography, leased networks provide zero percent of network access.

Although not required, we recommend that all of our members choose a primary care physician (PCP). Their PCP provides routine medical exams and gets to know each member and their medical history to direct their care. They also help members learn about and understand their health, and guide them on important health decisions. And, depending on their specific plan, seeing a PCP could cost less.

Our Choice POS II plan also gives members access to our tools, tips, programs and services that help them find network doctors, estimate costs and make informed decisions.

<sup>1</sup> Data represents behavioral health providers in our PPO-based plans as of 1/1/2026.

<sup>2</sup> Data represents our EAP providers available nationally as of 1/1/2026.

### **Open Access Aetna Select<sup>SM</sup> plan**

We are proposing our Open Access Aetna Select plan as a national solution. Our Open Access Aetna Select plan lets our members choose from quality in-network providers. Members can visit any doctor in our national network and they don't need referrals.

As of December 31, 2025, our national network has more than:

- 300,000 primary care doctors
- 1,762,000 specialists
- 6,100 hospitals
- 44,800 ancillary providers
- 488,999 behavioral health providers<sup>1</sup>
- 147,868 EAP providers<sup>2</sup>

Although not required, we recommend that all of our members choose a primary care physician (PCP). Their PCP provides routine medical exams and gets to know each member and their medical history to direct their care. They also help members learn about and understand their health, and help guide members on important health decisions and direct their care. And, depending on their specific plan, seeing a PCP could cost less.

Our Open Access Aetna Select plan also gives members access to our tools, tips, programs and services that help them find network doctors, estimate costs and make informed decisions.

<sup>1</sup> Data represents behavioral health providers in our PPO-based plans as of 1/1/2026.

<sup>2</sup> Data represents our EAP providers available nationally as of 1/1/2026.

**5. For bidders not proposing national network coverage, please describe available access for out-of-state residents (retirees and/or dependents of covered participants).**

Not applicable.

**6. Is the proposer willing to provide performance guarantees for your network discounting? If so, please include details.**

We have included a discount guarantee at 25% of collected fees at risk. Please see the financial package for specific information about our guarantees.

**7. Please confirm requirements for coordination with Medicare for both active employees and their dependents, as well as retired employees and their dependents.**

We have three methods for coordinating benefits with Medicare depending on the customer provisions or state regulation:

- 100 percent Allowable – This method allows payments up to 100 percent of allowable expenses incurred in a calendar year. An allowable expense is defined as any necessary and reasonable health expense, covered in whole or in part under our plan, which covers the person making a claim. When the primary plan pays on a charge that we don't cover due to the general exclusion of our plan, we consider it COB allowable if one of the plans covers the expense.
- Maintenance of Benefits - The primary plan pays regular plan benefits for covered expenses or the benefits payable if there were no other group health benefits plan in effect. The secondary plan may reduce its benefits to the lesser of either:
  - What it would have paid had it been primary
  - What it would have paid less the primary plan's payment

- Government Exclusion (This method only applies to Medicare) - Government Exclusion is a method of determining our payment when Medicare is primary for the member. When including this method, we consider the member's responsibility after the primary carrier has processed the claim.

When Medicare is primary, we base our benefits on either Medicare's approved amount for Medicare assigned claims, or Medicare's balance billing limit on Medicare non-assigned claims.

### **COB for employees and dependents**

We follow the National Association of Insurance Commissioners (NAIC) OBD rules to find out primary coverage responsibility. We apply COB order of benefit determination for dependents and children as outlined below.

#### Non-dependent/dependent rule

A plan that covers a person as a subscriber (non-dependent) pays benefits before a plan that covers the individual as a dependent.

#### A dependent child whose parents aren't separated or divorced

The plan of the parent whose birthday comes first in the calendar year, based on month and day only, is the primary plan of the dependent. The plan of the parent whose birthday comes later in the calendar year is secondary. If the other plan doesn't have this provision regarding birthdays, then the rule set forth in that plan determines the order of benefits.

#### A dependent child whose parents are separated, divorced or not living together

For a dependent child with divorced or separated parents, if there's a court decree that establishes financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of the plan that covers the child as a dependent of the parent with financial responsibility is primary before the benefits of any other plan that covers the child as a dependent child.

If there's a joint custody court decree which states that the parents share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the parent birthday rule described above applies to determine the order of benefits.

In the absence of court-decreed financial responsibility, if the parent with custody of the child hasn't remarried, the benefits of the plan that covers the child as a dependent of the parent with custody of the child is primary before the benefits of a plan that covers the child as a dependent of the parent without custody.

In the absence of court-decreed financial responsibility and if either one parent has custody or the child lives with one parent, then the order of birthdate is in this order:

- Parent with custody/child lives with
- Spouse of parent with custody/parent child lives with
- Parent without custody/child doesn't live with
- Spouse of parent without custody/child doesn't live with

In the absence of court-decreed financial responsibility when neither parent has custody and the child doesn't live with either parent, then the parent birthday rule applies to determine the order of benefits.

#### Dependents on spouse's plan and dependent on parent's plan(s)

- Under the Affordable Care Act, members can have coverage both as a dependent on their spouse's or domestic partner's plan and as a dependent under their parent's plan(s)
- One or both parents' plans can cover the dependent

If a spouse or domestic partner's plan covers the member and either or both parent's plan if one of the plans doesn't have a COB rule, then the plan without a rule is primary.

If members have coverage under both their parent's plans and their spouse's plan, the longer or shorter rule applies between all plans.

If coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, then the birthday rule applies to the parent(s) and the dependent's spouse.

**8. Each proposer must confirm that they will provide the following reports upon request by the City of Pompano Beach or its Agent of Record: a. Large Claimants (over \$25,000), inclusive of gender, plan, diagnosis, last date of service, prognosis, and if the claimant remains covered on the plan. b. Utilization reports by diagnosis, place of service, employee vs. dependent costs. c. Monthly paid claims**

Confirmed.

**9. Are you willing to conduct face-to-face meetings annually (including medical/pharmacy director and financial analyst support) with the client to discuss financial and program enhancement/cost containment ideas that will assist the client in benefit design strategy, and will not necessarily be focused on plan design coverage reductions?**

Yes. We have a reputation for providing industry-leading service and plan management consultation to our customers. We know that a personal relationship makes all the difference, and we understand that each customer is unique with specific goals and objectives. That's why your account team serves as an extension of your benefit team, providing day-to-day support and helping you shape future strategy through analysis and insight.

#### **Surrounding you with tailored support**

A connected, personal approach is at the heart of our account service model. We build an account management plan specific to you to drive accountability and mutual success. The plan includes the following:

- Annual strategic planning and review
- Quarterly account management meetings
- Monthly plan management meetings
- Day-to-day account management

We provide the right contacts and experts throughout our organization to ensure you're supported every step of the way.

### **Strategic review**

To promote collaboration and shape plan strategy, we meet at least annually to review your business goals, provide insights into our future direction and examine macro-trends driving opportunities and risks. We also discuss business-to-business endeavors and ensure strategic alignment between our two organizations as needed.

Your account team, supported by subject matter experts throughout our company, hosts meetings to focus on your data and results, and provides specific recommendations for plan improvement. Discussion topics include, but are not limited to:

- Strategic consultation and innovation
- Trend mitigation plans
- Plan performance
- Utilization measurement
- Deep dive analytics
- Clinical insight
- Custom network performance
- Member engagement levels
- Customer and member service issues and trends
- Annual enrollment planning, support and debrief

### **Plan management meetings**

Your account team consults with your team formally each month, and provides:

- Trend updates
- Mitigation strategies
- Consultative solutions
- Discussion of hot topics
- Utilization review, reporting and analytics
- Actuarial and underwriting support for plan change modeling

### **Day-to-day account management**

Your account management team works continuously with your benefits team to provide a best-in-class customer service experience for your company and employees by acting as your trusted advisor. This team is responsible for managing all aspects of our relationship, including:

- Proactively addressing and managing trends that concern you or us
- Promptly managing escalated employee issues
- Working with our internal business teams to provide the support your benefits team needs

Your account manager is your day-to-day contact and is always available for issue resolution. Initially, we recommend weekly account management meetings, led by your account manager, to ensure we are effectively managing all service needs.

### **10. Are you willing to waive the actively at work, dependent non-confinement limitation provisions for all currently enrolled individuals on medical?**

Confirmed. For our fully insured plans, any employee or eligible dependent that is covered by your benefit or service program as of the effective date is fully covered. All actively-at-work and non-confinement limitations are waived.

For our self-funded plans, actively at work clauses and non-confinement limitations are customer options.

### **11. Please list and describe your Disease Management programs that are included in the proposal.**

Included in our proposal is our care management program, Aetna One Flex. This program provides support to our highest risk members, placing an emphasis on treating comorbid conditions along with acute, episodic events. Additionally, our proposed well-being buy-up, Aetna Health Your Way - Achieve, offers broad population support through its Lifestyle and Condition Coaching program. Together, all three programs offer holistic support that meets our members' needs wherever they are in their health journey.

## **Disease management within Aetna Health Your Way™ Achieve**

Aetna Health Your Way™ Achieve is our evidence-based well-being program that brings health solutions directly to your members. Aetna Health Your Way includes a suite of capabilities to help your members manage and improve their well-being on their terms and according to their preferences. From a health assessment to curated well-being pathways (digital coaching), Aetna Health Your Way helps you improve the health and productivity of your employees. This results in better health outcomes, which can lower costs for you and your employees. Aetna Health Your Way focuses on prevention and health risk reduction to help you address health issues critical to the success of your business.

### Lifestyle and Condition Coaching (LCC)

Our LCC program allows members across all risk levels (low, moderate and high) to engage with a health coach telephonically or on video. The program is available to all members and their dependents who are 18 years and older.

LCC helps members identify and focus on their personal health and well-being priorities. These priorities may include tobacco cessation, weight management, stress management, nutrition, physical fitness or managing a chronic health condition. Members work with their coach to create a healthy action plan suited to their preferences and learning styles. A robust suite of online tools and engaging educational materials support this plan.

Our CareEngine®, which ingests data from multiple sources, including our health assessment, biometric screenings, activity data and claims, identifies participants for outreach. Members may also enroll in the program through a toll-free phone number.

### **Comprehensive disease management with LCC and Aetna One Flex**

Our Lifestyle and Condition Coaching program works alongside our Aetna One Flex program to break the cycle of rising health costs while improving clinical outcomes for our members. These programs coordinate together to ensure that members are supported and coached based on their individual situation and unique health needs. Our nurses and coaches take a whole health view of members and track their progress over time. We focus on acute and chronic conditions and emerging health risks and lifestyle factors.

Our vision is to improve the consumer health care experience by helping our members achieve their personal health ambitions. To support this vision, we built our Lifestyle and Condition Coaching and Aetna One Flex programs with personalization and engagement in mind. Using a personalized and engaging approach, these programs combine to assist members across the entire spectrum of potential health needs. We provide support from a multi-disciplinary team, along with comprehensive digital interaction points and the convenience of connected devices that provide near real-time data sharing.

Lifestyle and Condition Coaching and Aetna One Flex are at the forefront of what's possible for health care delivery, leveraging deep analytics, integrated technology and advanced predictive modeling to find those who need help the most in a manner that's meaningful to them and their health goals. Whatever their health needs, we offer members the right kind of support to:

- Reinforce and broaden existing healthy behavior
- Improve lifestyle choices
- Manage acute and chronic conditions
- Address emotional well-being and women's health concerns including perimenopause and menopause

#### An integrated, holistic approach to care

Our Lifestyle and Condition Coaching program is an integral part of any comprehensive population health strategy. The program provides support for a wide array of lifestyle and well-being needs along with many chronic co-morbid conditions that are costly and debilitating. Members receive the right support at the right time in the right way to meet their needs and encourage sustained engagement. Our program helps members form long-term healthy habits and successfully manage their chronic conditions through a single-coach model with the support of a multi-disciplinary team. Lifestyle and Condition Coaching provides specific focus on rising-risk members who need support making lifestyle changes to reduce their overall health risk and help limit future health care costs.

For greater chronic and acute care needs, members receive the right combination of digital and one-on-one nurse support with our Aetna One Flex program. As their needs change, we let them shift seamlessly between programs. Clinicians connect with members in their current state of health and anticipate how their health may change over time. Our Aetna One Flex program provides specific focus on high-risk members with active impactable risk factors such as new diagnoses, poor symptom management, recent hospitalizations and recurring disease flare-ups.

#### Coordination between programs

We believe that a single nurse point of contact is very important. To that end, we've established a hierarchy within our programs to identify a primary contact when the member qualifies for more than one program. Because of our integrated clinical management approach, all nurses and multidisciplinary resources (such as social workers and behavioral health specialists) on the care team have a comprehensive view of member information. When the member qualifies for both care management and condition management, the care manager is the primary initial contact. The care manager coordinates acute health needs through our Aetna One Flex program, such as care needed after a hospitalization.

Our Lifestyle and Condition Coaching team coordinates with care management to provide focused support for chronic conditions and lifestyle factors through phone, e-mail, SMS and group sessions to positively impact health. When a member's clinical needs have been met, they may then be engaged by our Lifestyle and Condition Coaching program to address certain chronic conditions and lifestyle factors.

By providing support across the entire spectrum of health needs and engaging members of varying health risk, we're able to identify, target and focus our efforts on improving the health and well-being of your employee population. This helps serve your overall population health strategy by reducing costs and improving health outcomes.

**12. Please list and describe Utilization Management programs included in the proposal and other available options, if applicable.**

Our utilization management programs effectively support your employees and their families by ensuring they receive the care they need.

We accomplish this through:

- Early identification of members for referral to other programs, such as care, disease or maternity management, disability or behavioral health
- Identification of the most cost-effective network providers
- Early discharge planning
- Steerage to Aetna Institutes of Excellence™ and Institutes of Quality®

**Precertification**

Precertification is the process of collecting information before inpatient admissions and select ambulatory procedures and services. The process permits advance eligibility verification, determination of coverage and communication with the physician or member. It also allows us to coordinate the member's transition from the inpatient setting to the next level of care (discharge planning) and to register members for specialized programs like our maternity management program.

We use precertification to help members and physicians make more cost-effective decisions about scheduling and to help manage outpatient surgical procedures, along with low-tech and high-tech radiology.

**Concurrent review and discharge planning**

Our clinical team reviews inpatient admissions (except normal maternity care) while the member is in the hospital. We use proven standards of care as guidelines to help make sure care given is necessary and covered. Not all inpatient admissions require this clinical review. For example, routine admissions with a short length of stay normally don't need concurrent review.

Our clinical team determines the frequency of review on a case-by-case basis. They base it on the member's clinical progress and our internally developed Focused Interaction Tool (FIT).

Our review process helps lower the average length of hospital stays and helps members get quality care.

We also help members get the care they need after they leave the hospital. Our proactive discharge planning begins during the hospital stay. We work with doctors, members and their families to develop a transition plan from one level of care to the next.

This helps keep the member cared for and comfortable and helps lower health care costs.

### **Care management**

We originally designed the program using industry and state requirements and have evolved it over time based upon experience and corresponding data. We modified it by assessing population needs and using evidence-based best practices in managing complex illnesses and conditions.

The care management program is a collaborative process based on:

- Assessment
- Development of a care plan
- Implementation
- Coordination of services
- Monitoring
- Providing options and services to meet an individual member's health care needs

It focuses on the continuum of care, addresses the health care needs of members and stresses medically appropriate care and member involvement in the health care process. Communication with the individual member, caregivers and health care providers, combined with enhanced care coordination, assists in promoting quality, cost-effective outcomes. All eligible members have the right to participate. Members can decline participation at any time by opting out of the voluntary program. During our utilization reviews, we find members who can benefit from a nurse care manager to help prevent more significant health events.

### **A key to program success**

Good communication is the key to the engagement that drives success. We use our reviews as opportunities to educate members and physicians on the right care, at the right time for a more cost-effective price. We also refer members to personalized programs to help meet their needs.

The key is making healthy choices convenient and easy to keep members engaged. Engaged employees are healthier, more productive and have lower total health care costs.

### **13. Please confirm dependent child(ren) eligibility.**

Confirmed. Our standard definition of an eligible dependent child, married or unmarried, from birth up to 26 years of age includes:

- Biological children
- Stepchildren, including children of covered domestic partners when the plan provides domestic partner coverage for all employees
- Legally adopted children and proposed adoptive children
- Foster children, including any children placed with the employee for adoption
- Children for whom the employee is responsible for under court order
- Grandchildren who meet the applicable grandchildren eligibility requirements
- A handicapped dependent, defined as a dependent above the limiting age that is incapable of self-support due to mental or physical handicap which began prior to the limiting age

Most of our contracts state that an individual is eligible for coverage if they are a regular full-time employee, who normally works at least 25 hours a week and is actively at work on the effective date unless otherwise noted in your plan documents.

**14. Please confirm the proposer has included the telemedicine benefit in the medical quote. Please confirm if this includes mental/behavioral health.**

Confirmed. Included in both of our fully insured and self-funded quotes is our CVS Health Virtual Care™ program.

CVS Health Virtual Care™ offers 24/7 general medicine alongside scheduled mental health services, providing members with convenient access to comprehensive virtual care. Mental health services include support for depression screening and medication management, as well as scheduled counseling and psychiatry visits.

Members have access to a broad range of mental health services designed to support emotional well-being across life stages. These services include therapy for anxiety and mood disorders, as well as support for stress management, life transitions, conflict resolution, depression, grief, sleep concerns, and related health behaviors. Psychiatry services are also available for mental health evaluations, prescriptions, and ongoing medication management.

CVS Health Virtual Care™ mental health services are supported by a network of licensed mental health professionals delivering high-quality counseling and psychiatric care. Available mental health counselors hold licensure such as LCSW, LMFT, LMHC, LPC, LISCW, and psychologist. Psychiatric prescribers, including PMHNPs and FNPs, support select scheduled services such as evaluations and medication management. CVS Health Virtual Care™ continuously evaluates demand and scales capacity as needed to help ensure members have appropriate access across all mental health lines of service.

**15. For plans that provide out-of-network coverage, if radiologists, anesthesiologists and pathologists are not part of the network, is the member responsible for cost at the in-network or out-of-network reimbursement levels?**

When a member receives services at an in-network facility and by an out-of-network hospital-based physician, we cover the services at the in-network benefit level. These services typically occur in conjunction with emergency care and outpatient and surgical care. Hospital-based physicians (HAIRPNs) typically include: anesthesiologists, emergency physicians, pathologists, radiologists, hospitalists, intensivists and neonatologists.

The Federal No Surprise Act (NSA) protects members from the costs of unplanned medical bills from nonparticipating providers. These bills may occur when members receive care at an in-network facility and from nonparticipating providers who perform services as part of the facility's service. Members typically don't have an opportunity to choose a provider.

For self-funded plan sponsors that haven't opted in to any state surprise bill regulation, HAIRPNs services by out-of-network providers at in-network qualifying facilities are subject to the Federal No Surprises Act (NSA). The NSA requires health plans to process out of network provider claims issued in qualifying facilities at the plan's in-network benefit level and to calculate the in-network cost share based on the Qualifying Payment Amount (QPA). The QPA is the median of the carrier's contracted rates for the same service or supply in the same geographic region, based on 2019 contracts and adjusted as required by the NSA. To calculate the member's cost share based on the QPA, we have to allow the QPA for covered services.

The NSA doesn't protect the member if the service isn't a covered service and the member has signed a consent form agreeing to out-of-network care.

Our claims system supports this process, and it typically wouldn't require manual processing.

#### Contracts with hospital-based physicians

In some markets, the hospital directly contracts and reimburses hospital-based physicians such as radiologists, anesthesiologists and pathologists. In other markets, we directly contract and reimburse hospital-based physicians in accordance with an agreed fee schedule.

We continuously work to contract with hospital-based physicians. Our hospital contracts instruct network hospitals to assist in that effort. We also have a policy in place to protect members by covering services from out-of-network hospital-based physicians in network facilities at the in-network benefit level.

#### **Emergency care coverage**

In the case of a true emergency, the member may seek medical care at the nearest emergency facility. We cover emergency room services at the preferred benefit level, regardless of the facility's participating status. These covered services include radiologist, anesthesiologist, pathologist, laboratory, hospital laboratory and emergency room physician services. If an out-of-network provider bills the member, we hold the member harmless for amounts above the plan cost share.

We reimburse out-of-network providers in accordance with the appropriate recognized charge. Our reimbursement rates comply with applicable state regulations. For large dollar amounts, we try to negotiate a rate with the provider.

**16. How do you handle the transition of care for members currently undergoing treatment or have existing relationships with the incumbent carrier's network providers?**

Our transition of care coverage allows a member in an active course of treatment to continue the treatment for a limited time at a higher benefit level. We define active course of treatment as a program of planned services that:

- Starts on the date a provider first renders a service to correct or treat the diagnosed condition
- Covers a defined number of services or period of treatment
- Includes a qualifying situation

During the transition, we provide Transition of Care Coverage Request forms and "Transition of Care Coverage Questions and Answers" communications to you. You can then give these forms to those employees who wish to apply for our transition of care coverage. Members may also request forms by contacting member services. Once we receive the completed forms we review the submitted information for continued treatment approval.

We don't automatically identify members for special handling. The doctor or member is responsible for initiating this process by sending us a completed Transition Coverage Request Form.

Our clinical team, including a medical director or licensed behavioral health clinician, performs the following as needed:

- Reviews the coverage request to verify that the correct team received it for processing
- Records receipt of the transition of care coverage request in our clinical management system when member eligibility becomes available
- Verifies member eligibility
- Verifies that the forms are complete and signed
- Verifies that the service is not a plan exclusion
- Determines whether we can approve the transition of care coverage request based upon the information submitted or whether we need additional information
- Documents the transition of care request decision

- Provides a notification of the decision including:
  - The reason for the denial
  - The clinical rationale used to support the decision
  - The clinical criteria used to make the determination upon request

Examples of medical conditions that are appropriate for transition of care consideration include, but are not limited to:

- Pregnancy in the second and third trimester
- Rehabilitation for an acute or short-term condition
- Surgery pre-approved before the new plan effective date but scheduled within three months of the new plan year
- Cancer treatment
- Inpatient or outpatient mental health or chemical dependency treatment
- Outpatient intravenous therapy for a resolving condition
- Advanced stages of terminal illness
- Chronic renal dialysis
- Solid organ or bone marrow transplant
- Infertility

We make transition of care benefit determinations within the precertification timeframe.

### **Provider nominations**

You're welcome to contact your account representative and members can email or call Member Services to nominate a provider for our network. Our teams forward the provider nomination information to our credentialing unit for eligibility and network review.

### Physician nominations

If the physician is in a network area where we are pursuing applications for their specialty, we send a nomination communication. It includes information on how to request an application to join the network. Physicians who return the application request undergo credentialing. If the physician is in a rental network area, we send a nomination communication and request they contact the designated rental vendor directly for consideration.

We send the first nomination communication to the provider within 30 days of the nomination and follow-ups if needed.

We accept physicians into the network if they meet our quality and business criteria.

Once we receive all required documentation, it may take 90 to 120 days to credential and add a physician.

### Hospital or facility nominations

We forward the hospital or facility nomination information to the appropriate local market network manager for review.

We accept hospitals into the network if they meet our quality and business criteria.

Once we receive all required documentation, it may take up to a year to add a hospital.

### Notifications

Upon request, the account representative provides you with an update of the nomination status and you may notify the member. We don't directly notify the member if we add a physician or hospital they nominate to our network.

Members can check if a physician or hospital participates in our network by searching online in our provider directory or by calling Member Services.

We haven't historically tracked the number of physicians or hospitals added from member or customer nominations.

**17. Please describe your prior authorization process, specifically as it relates to high-cost specialty medications (such as Ozempic, Mounjaro, etc). Please confirm if you are able to accept a file of current authorizations and if there is a cost associated with this.**

We don't prescribe GLP-1 drugs as part of our medical benefit administration. However, we do offer programs focused on diabetes prevention and diabetes management. We also offer programs focused on weight management.

While our Transform Diabetes Care program doesn't include prescription of any medications, one of the program's areas of focus is medication optimization. This includes application of American Diabetes Association (ADA) guidelines to make anti-diabetes drug classification recommendations to the member which can then be discussed with the member's provider. Transform Diabetes Care has not been shown in your quote at this time.

**Precertification**

We apply our National Precertification List (NPL) to all medical outpatient services. We require precertification for certain complex, high-cost therapies and treatments. Our approach improves the quality of care while lowering costs for our members. With precertification, we make sure that members are receiving the drugs that they need while avoiding waste. We do this by approving the right dose, steering to the most appropriate site of care and following a recertification process that ensures continued effectiveness of therapy. Because of our strong provider relationships, they know our guidelines and have increasingly adhered to them over time.

Our full list of drugs that require precertification is available at [Aetna.com/health-care-professionals/precertification/precertification-lists.html](https://www.aetna.com/health-care-professionals/precertification/precertification-lists.html)

Real-time feedback with our prior authorization tool

Our online, real-time access automated prior authorization tool allows providers to enter precertification requests and receive immediate feedback on preferred drug strategies, site of care opportunities and other coverage requirements, enabling a more seamless experience for providers. It also integrates with our pharmacy benefit tool when a provider needs to send a request to that benefit. The tool provides claim editing capabilities for complex drugs and allows edits that are personalized to member-specific dosing.

### Precertification criteria

You can access our precertification criteria in our Clinical Policy Bulletins (CPBs) at [Aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html](https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html)

We track these drugs by drug name, dose and indication for use. We only pay claims if they have authorization in our system.

The CVS Caremark National Pharmacy and Therapeutics (P&T) Committee, in partnership with Aetna, provides clinical input on all medical specialty formulary decisions. These decisions include an extensive review of FDA-approved drugs. We base our coverage criteria and decisions on efficacy first. If efficacy is equal, then we look at cost.

### Accepting prior authorizations from the incumbant carrier

For our self-funded customers, prior authorization cases are part of the standard transition process as of January 1, 2026, for all commercial business. The standard for transition of case will be 90 days effective January 1, 2026 unless the plan sponsor has an exception. Please note we require a signed Hold Harmless agreement for self-funded customers.

### **18. Are you willing to honor each member's deductible and out-of-pocket maximum accumulation credits (if applicable)? Please advise what reports you would need in order to honor each member's accumulation credits.**

Yes. We meet with you to discuss the transfer of financial information as soon as we are selected to administer your plan. To correctly process claims, we need a list of financial accumulators for each employee and dependent. The list may vary based on your needs and can include:

- Coinsurance amounts
- Deductibles
- Out-of-pocket limits
- Annual and lifetime maximums
- Visits
- HRA fund balance rollover

To load this data into our claims system, we need the following information:

- Subscriber's Social Security number
- Claimant's last name
- Claimant's first name
- Claimant's relationship to employee
- Claimant's date of birth (YYYY-MM-DD)

### Format and timing

We accept the information in both Microsoft Excel® (preferred method) and text delimited formats. We accept these formats through an email that is password protected or through a secure file transfer protocol online. The first file should come to us from the prior carrier at least two weeks before the effective date. There's no charge to transfer the accumulator data to us.

Because the prior carrier continues to process claims during the run-out period, this data can quickly become outdated. To keep data current, we suggest a subsequent update one to two months later to capture run-out claims. There's no additional charge for the second and third accumulator file. There's a charge for each ongoing accumulator file received from a third-party pharmacy or behavioral health vendor on a bi-weekly or monthly basis.

## Questionnaire – Wellness

**1. Please confirm that your proposal includes annual Wellness Funds and the amount you will be providing annually. Please outline how the funds can be used and if any conditions apply.**

Our wellness funds vary by funding type as described below.

### Fully insured

We have included a \$100,000 Wellness and \$50,000 Technology allowance as part of our financial proposal. In general, allowances must be used for expenses directly related to the administration of your Aetna plan. Our financial proposal documents provide a detailed description of how we administer the Wellness and Technology allowance and outline our terms and conditions. The Financial Information section of our proposal response includes these documents.

### **Self-funded**

We have included a \$150,000 Health Plan Allowance as part of our financial proposal. In general, you must use allowances for expenses directly related to the administration of your Aetna plan. Our financial proposal documents provide a detailed description of how we administer the Health Plan Allowance and outline our terms and conditions. We include these documents in the Financial Information section of our proposal response.

## **2. Are there any additional costs to the City of Pompano Beach or employees to participate in your wellness programs or services?**

The costs of our wellness programs vary by funding as described below.

### **Fully insured**

We have included our standard fully insured well-being programs in our quoted rates.

We are proposing Aetna Health Your Way Achieve on an optional basis, for an additional premium cost. Our financial proposal documents provide pricing for programs available on an optional basis, and any applicable terms and conditions. These documents are included in the Financial Information section of our proposal response.

### **Self-funded**

We have included Aetna Health Your Way Core in our self-funded proposal. The cost of the program is included in the per employee, per month administrative fee.

We are proposing Aetna Health Your Way Achieve on an optional basis, for an additional cost.

Our financial proposal documents provide a list of programs included in our pricing, pricing for programs available on an optional basis, and any applicable terms and conditions. These documents are included in the Financial Information section of our proposal response.

**3. Will the account team assigned include a designated wellness coordinator? If so, which wellness services will be included?**

For our Aetna Health Your Way – Core program, which is included with all of our proposed plans, we don't offer the option of a well-being coordinator at this time.

However, for our Aetna Health Your Way – Achieve program that is being offered as a buy-up for all of our proposed plan options, we do include a designated well-being program consultant. Working collaboratively with you, your well-being program consultant acts as an extension of your Account team to help you build an effective strategy that meets your short and long-term well-being goals. Your well-being program consultant can:

- Assist with the development, coordination, management and maintenance of your well-being programming to reduce health risk and medical costs, as well as encourage healthy lifestyles
- Help define practical and actionable well-being goals as well as gather and define baseline data and measures of success over time
- Participate in discussions with well-being committees and well-being champions to drive goals and advance a culture of well-being
- Leverage existing programs, relationships and resources to use well-being dollars wisely (if applicable)
- Assess and evaluate health promotion programs, such as biometric screenings and health assessments (if applicable)
- Support onsite services and work with third-party administrators to vet and implement new solutions and maintain current vendor relationships (if applicable)
- Answer questions about well-being programs and encourage participation in available programs while coordinating referrals to appropriate programs, as necessary
- Recommend meaningful incentive strategies that drive participation in new and existing programs

Your well-being program consultant also has access to our reporting and analytics platform, ART. This platform helps identify key cost and utilization drivers, as well as social determinants of health (SDOH) affecting your employee population.

**4. Will you attend Wellness Events throughout the year? If so, how many? Are there any related costs for attendance?**

Yes. As mentioned previously, one of the roles of our well-being program consultants is to support our customer's benefits and total rewards team in various well-being events (onsite, virtual and hybrid). Through these events, well-being program consultants answer questions about well-being programs, encourage participation in available programs and coordinate referrals to appropriate programs as necessary. The well-being program consultant works with cross-enterprise partners and other vendors to deliver tools and resources to execute the strategy. The account management team and the well-being program consultant will work with you to collaborate on the number of wellness events to attend throughout the year. There is no additional cost for attending wellness events.

**5. Does your company offer rate discounts on the proposed programs, in dollars or percent, to employer groups who implement an active, participatory Wellness Program? If so, please describe the discount model, the amount, and the requirements.**

No. We do not offer any rate or fee discounts to the proposal, but your Health Plan Allowance can be used to support wellness initiatives.

**6. Does your wellness program provide a proactive health education and improvement program for those with a chronic condition?**

Yes. Our well-being content and tools aren't customizable, but they are personalized, offering a great member experience.

**Personalized member experiences**

We use data persistence to continuously update, personalize and simplify the user experience on our Aetna Health Your Way™ well-being platform. After taking the health assessment, members receive a unique numeric health score (MyHealth100) which shows their current health state. Based on their MyHealth100 score, we offer members prioritized well-being goal options to improve their health. Each goal includes a simulated improvement score.

Aetna Health Your Way pathways are personalized, guided well-being experiences that include goal-based check-ins, AI powered content recommendations, educational materials and a curated health checklist. Our purpose-driven pathways encourage members to set health goals and offer daily check-ins to stay motivated and accountable as they pursue committed objectives to improve their health

After the member has selected a well-being pathway, additional health and well-being content is available to members in a variety of formats and search preferences in our Explore section. We offer the latest health content from award-winning vendors. This includes information on medications, health topics, tests and procedures, as well as community-based resources, webinars, health articles, recipes and interactive videos. Industry experts research, create and review our market-leading educational content. This helps ensure all content is accurate, unbiased and refreshed monthly. Another exciting feature of the pathway member experience is our proprietary AI-powered content recommender. While on their pathway, members are presented with a curated health checklist with important tasks for them to complete, including personalized content, open health actions, prompts to connect a device for activity tracking, etc. The interactive checklist displays the activities that are open, and those the member has completed.

Completing our content preferences survey enables personalized recommendations for the member in the “Recommended For You” section. As members engage with content, they can upvote or downvote based on their experience. These votes are aggregated to highlight trending topics popular with other users, enhancing the platform’s social aspect.

We work collaboratively with you to provide the right information and support for your well-being benefit strategy.

**7. Does your wellness program utilize behavioral coaching principles and evidence-based medicine guidelines to optimize self-management skills to foster sustained health improvement?**

Yes. Our nurses help guide members to make lasting behavior change through motivational interviewing techniques. These techniques help them discover the member’s goals and what motivates them to make sustainable behavior change. Nurses uncover possible hurdles to making positive behavior change and help members eliminate or manage these obstacles. They focus on the member’s internal desire to change rather than just general education.

Motivational interviewing is at the core of our program. This is evident in our:

- Tools - Rather than just training employees in motivational interviewing, we give them tools to develop expertise and confidence. Our team gains valuable information from peer supervision and social network resources.
- Caller priorities - Because a human touch is important, we've reduced the use of scripts and formal assessments. Conversations are led by the member's needs, not a script.
- Sophisticated analytics - Measuring the results of our program helps us stay in tune with member needs. We measure individual responses and evaluate the impact on member behavior and cost benefits.
- Personalized care plans - Based on our discovery of the member's internal motivators and through system-driven assessments, nurses create a care plan specific to the member through one-on-one nurse support or virtual, self-directed care.
- Digital support - Members may prefer to use online programs to manage their health. These programs replicate the successful behavior change methodology used by our nurses and include tailored messaging technology that helps improve engagement rates, program completion and outcomes.

Having a trusted person to support them keeps members engaged and motivated. This helps us provide more impactful care support, leading more members to achieve their health ambitions.

### **Coaching through Lifestyle and Condition Coaching (LCC)**

Our proposed buy-up, Aetna Health Your Way - Achieve, includes our Lifestyle and Condition Coaching program. Our coaching model is deeply rooted in evidence-based practices backed by qualified research including the U.S. National Library of Medicine and PubMed. Our approach to behavior change employs evidence-based methods, including motivational interviewing, cognitive behavioral therapy and behavioral economics, which are endorsed by leading health organizations such as the American Medical Association, the American Heart Association, the American Academy of Pediatrics and the Agency for Healthcare Research and Quality.

Our evidence-based behavior change coaching uses the principles of self-determination theory to help members establish their own personal path to health and well-being. Coaches provide non-judgmental support to help members define personal well-being goals and overcome any obstacles to success. With ongoing support, coaches help to improve the member's self-efficacy, foster accountability and inspire intrinsic motivation, which promotes engagement and sustainable behavior change. Evidence indicates that if coaches offer support, encourage accountability and examine and resolve a member's ambivalence about changing, there's a better chance that individuals develop self-management skills and coping strategies which help them overcome obstacles they may face.

### Motivational interviewing

We use motivational interviewing approaches to identify issues and explore base motivation to make lifestyle changes and address ambivalence. Coaches use a direct approach to point out inconsistent positions and then actively support positive behavior change choices resulting in accountability for lifestyle choices.

Motivational interviewing is a form of collaborative conversation that helps strengthen an individual's own motivation and commitment to change. It's a person-centered counseling style for addressing the common problem of ambivalence about change by paying particular attention to the language of change. It's also designed to strengthen an individual's motivation for and movement toward a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion.

Motivational interviewing techniques use four methods to achieve its ends: engagement, focus, evocation and planning.

- Engagement – Involves the individual in talking about their issues, concerns and hopes while helping establish a trusting relationship
- Focus – Narrows the conversation to habits or patterns that individuals want to change
- Evocation – Elicits individual motivation for change by increasing the member's sense of the importance of change, their confidence about change and their readiness to change
- Planning – Develops the practical steps individuals want to use to implement the changes they desire

### Conscious inclusion

Our coaches are trained in conscious inclusion, cultural awareness, empathy and listening. Our assessments also address physical limitations, health literacy, language needs and learning preferences. Coaches have access to certain demographic information on members including preferred language, preferred form of address, ethnic group, marital status, gender identity, sex assigned at birth and sexual orientation. All of this information helps us further engage members in a personalized manner that is best suited to their preferences which can help support behavior change.

### **8. Does your wellness program include: a. Chronic condition-specific coaching? b. Pre- and post-discharge calls? c. Lifestyle management coaching: stress, weight management, and tobacco cessation? d. Treatment decision support and coaching?**

Yes. Included in our proposal is our Aetna One Flex program and our Aetna Health Your Way™ Achieve buy-up. While Aetna One Flex targets our highest risk members and offers services such as post-discharge calls, Aetna Health Your Way™ Achieve is our evidence-based well-being program that complements Aetna One flex by offering digital support, engagement and self-management tools to help your members manage and improve their well-being on their terms and according to their preferences.

### **Lifestyle and Condition Coaching (LCC)**

Included with Aetna Health Your Way™ Achieve buy-up is our LCC program that targets chronic conditions and provides disease management. LCC allows members across all risk levels (low, moderate and high) to engage with a health coach telephonically or on video. The program is available to all members and their dependents who are 18 years and older.

LCC helps members identify and focus on their personal health and well-being priorities. These priorities may include tobacco cessation, weight management, stress management, nutrition, physical fitness or managing a chronic health condition. Members work with their coach to create a healthy action plan suited to their preferences and learning styles. A robust suite of online tools and engaging educational materials support this plan.

Our CareEngine®, which ingests data from multiple sources, including our health assessment, biometric screenings, activity data and claims, identifies participants for outreach. Members may also enroll in the program through a toll-free phone number.

### **Post-discharge calls**

As a part of our included Aetna One Flex program, we conduct post-discharge calls. All members with a scheduled admission who are discharged from a hospital receive a post-discharge outreach. This occurs within seven business days of their discharge. We do not perform post-discharge calls for outpatient surgeries, maternity, newborns, behavioral health, coordination of benefits (COB) or Medicare. If a member transitions from an inpatient setting to a skilled nursing or acute rehabilitation facility, the post-discharge call occurs once the member is discharged from these facilities. The goal of our outreach is to prevent avoidable readmissions.

We don't measure post-discharge outreach in our standard reports but use readmission reporting for insight.

### **Digital solutions**

Aetna Health Your Way offers a dynamic, intuitive and personalized well-being platform for app and web with focused self-guided digital coaching for members to learn and sustain healthy habits in body, mind and spirit. The gamified format promotes and rewards member engagement with enhanced features that drive behavior change through goal-setting, motivation and encouragement to complete activities and earn rewards.

Our platform leverages the latest technologies including artificial intelligence (AI) and machine learning (ML) using evidence-based health information. Our well-being platform aligns with the evolving needs and expectations of our members, including using traveler and explorer personas for members to navigate their pathway.

In addition to a proprietary health assessment and personalized well-being pathways, our well-being platform offers other proprietary programs and features, including:

- A unique MyHealth100 score
- An AI content recommender
- An interactive health resources library (articles, videos, audio recipes and community-based resources) personalized by content preferences
- An incentive program with rewards using "hearts" digital currency and personal challenges
- Recommendations for personal (telephonic) coaching and group coaching
- A mental health check-in

- Well-being webinars and trending well-being content
- Activity and device tracking and reporting

Our well-being platform also offers gift card fulfillment services.

### **MyHealth100**

Our well-being platform includes MyHealth100. This is a new tool that gives a unique health score to each member after they complete our health assessment. Derived from our proprietary Aetna Health Your Way Index, MyHealth100 empowers participants to actively manage their health by analyzing each member's health profile and issuing a score (0 to 100) that's easy to understand and encourages them to take action to improve their health score. MyHealth100 drives personalized member pathway recommendations that focus on the aspects of health they want to improve.

### **Well-being pathways**

We offer nine different well-being pathways as part of our digital coaching support with varying intensity levels as determined by the member's health profile. These pathways feature the following coaching topics:

- Be More Active
- Reduce Your Diabetes Risk
- Manage Your Stress
- Get Restful Sleep
- Manage Your Blood Pressure
- Reduce Your Health Risks
- Make Healthier Food Choices
- Say Goodbye to Tobacco
- Manage Your Weight

The duration of each pathway varies based on the selected pathway and intensity level for each goal. These purpose-driven pathways encourage members to set health goals and offer varied daily check-ins to stay motivated as they pursue committed objectives to improve their health.

Aetna Health Your Way takes a holistic approach to pathways by offering a daily mood check-in during the pathway experience. The mood check-in is a new feature that poses a single question to help members reflect on how they're feeling each day in relation to their goals. Members rate their mood on a scale of 1 -10. If a member's rating is between a 1-3, we display emergency resources to the member (911, 988 and National Suicide Hotlines).

Another significant part of the pathway experience is our proprietary AI-powered content recommender. It learns about the member's health state to recommend personalized content and refreshes post-completion. Members can view the content as a daily activity. While on their pathway, members receive a curated health checklist with important tasks for them to complete. This includes open health actions, prompts to connect a device for activity tracking, personalized recommendations for coaching options (personal 1:1 and group) and all available client-incented activities.

The interactive checklist displays the activities that are open and those the member has completed. For example, during their initial pathway check-in, members learn about the option of connecting a device. The devices suggested are specifically related to their chosen pathway goal. The pathways and the curated health checklist within each pathway create a personalized, focused experience that guides the member towards a clear goal.

### **Curated content**

After the member has selected a pathway, additional well-being content is available to members to learn more about their health in our Explore section. We ensure our content is relevant and accurate with well-being advancements and trends by using award-winning health content vendors. This includes Healthwise, Dotdash Meredith and FindHelp.org. We offer the latest well-being content, including information on medications, health topics, tests and procedures, as well as health articles, recipes, interactive videos and much more.

### **Challenge programs**

Aetna Health Your Way also offers a variety of well-being challenges designed for personal participation. Our challenges leverage the core tenets of game mechanics, animation, incentives and social competition to create a fun experience to motivate your employees. Aetna Health Your Way's challenge program leverages science and evidence-based medicine to promote sustained engagement, incremental habit adoption and healthy competition.

### **Incentive strategy and rewards**

Our well-being platform employs an incentive strategy grounded in the science of behavior change to promote daily engagement. By integrating established habit-building techniques, the platform leverages gamification and incremental feedback to foster the development of healthy behaviors. All activities within the platform are rewardable with "hearts", a digital currency that members earn as they progress toward their goals and complete incentivized activities.

We provide clients with a turn-key reward program that features a built-in menu of activities for hearts gamification and pre-set heart values for specific actions. The value of a heart is standardized at 100 hearts to one dollar, allowing for a straightforward client configuration of reward values. Members can easily view available incentives and track their progress using the platform's health checklist.

Our platform incorporates a broad range of offerings to encourage and reward healthy behaviors beyond initial enrollment and completion of a health assessment. This incentive design approach ensures that members remain engaged in activities that deliver the greatest benefit and impact to their health.

### **Health decision support**

Our included Aetna One Flex program also provides health decision support. Employees and their families may be faced with a new diagnosis or health care decision at any time. Our well-being platform uses best-in-class Healthwise Knowledgebase's library of online learning videos and interactive tools to give members the information they need to make better decisions about their health. These resources educate members on a variety of common conditions, treatments, procedures and surgeries, and help them pick the best course of action for their health.

The programs are engaging and interactive, encouraging thought, preparation and discussion. They provide information in a clear, concise manner and help members weigh the benefits and risks of their different health care options, as well as discuss those options with their doctors. With Healthwise Knowledgebase, members can review over 8,000 health topics, watch more than 700 informational videos, view detailed images and illustrations and have access to an interactive symptom checker.

Members have 24/7 access to Healthwise Knowledgebase through our member website.

## Questionnaire - Mental/Behavioral Health

### 1. Describe how your integrated offerings engage those with unaddressed behavioral health concerns or needs. Do you have any outcome metrics that show the success of these measures and the impact on overall medical costs?

Medical/behavioral health integration is a core competency and at the heart of all we do. We provide members with both medical and behavioral health conditions with health and lifestyle management support. Medical nurse case managers screen members with a medical condition for other impacting issues including behavioral health concerns, stress and social determinants.

When a member is found to be struggling with behavioral health, stress, and/or social concerns, the nurse can request a consultation with a behavioral health resource. In fact, a behavioral health clinician is assigned to each medical team. Through consultation, we provide the medical nurse with the right clinical and resource options to support the member's needs. With each, our care management staff screens to identify the following behavioral health issues:

- Anxiety
- Alcohol use
- Eating disorders
- Bipolar screening
- Depression

Medical nurses address most "routine" issues - such as feeling stressed, overwhelmed, irritable, nervous, anxious or worried. A behavioral health clinician provides support and guidance to the nurse in coordinating the member's care.

When we identify members with needs that are more complex, the medical nurse case manager refers them to our behavioral health case management team. This can be done via warm transfer and our shared clinical system. From that point, the medical nurse case manager helps the member manage the medical concerns, while the behavioral health case manager supports the member with behavioral health concerns.

Both case managers collaborate and coordinate on multiple levels including ad hoc consultations, attending joint medical rounds and reviewing care notes in our shared clinical system.

By providing a blended, holistic approach to our member interactions and through enhanced screening, our staff now has the ability to see and address all co-morbidities as they affect the member.

Specifically, this will aid and impact:

- Identification - Care management teams are better able to identify behavioral health conditions for the members who have triggered for their program and mitigate the behavioral health impact on acute and co-morbid medical conditions. Conversely, behavioral health team members have care management team members available to discuss medical conditions for the membership they manage when they identify medical co- morbidities.
- Assessment - The care management team quickly assesses the severity of the behavioral health condition and the impact on the member's medical conditions. This is the key driver to determine the next steps for the medical management team, as they incorporate behavioral health components into the members' plan of care.
- Care management - The care management team manages the member more holistically through the continuum of care, addressing both medical and routine behavioral health gaps in care. They work closely with the behavioral health clinician(s) to determine the most appropriate care for the member through consultation, co-management and case conferencing.
- Outcomes - With continued cross-collaboration and integration of the care management and behavioral teams, the member will receive holistic quality care in a cost-effective manner. Customers will see for their members improved and sustained health outcomes.

The goal is a clinical model that demonstrates real integration of care across all programs and populations to:

- Identify and addresses routine behavioral health issues by leveraging behavioral health and medical management expertise
- Improve the effectiveness of medical interventions and outcomes by addressing behavioral health drivers of medical outcomes.

## **The success of our behavioral health programs**

Integration advantages include earlier identification of BH issues, improvement of medical outcomes, increased member involvement with management of physical, mental and emotional well-being and increased participation in our BH and BH condition management programs. All of this helps create a positive impact on cost savings.

### Behavioral Health Condition Management BoB clinical results

For our Behavioral Health Condition Management program included only with self-funded quotes, in 2025, engaged members saw a 32.16 percent improvement in depression and a 35.73 percent improvement in anxiety based on the difference from the initial and final assessments for each case. Additionally, we saw on average 1.66 days at work gained per month and a 59.66 percent program completion rate.

## **2. Describe how you assist members in navigating and identifying available behavioral health appointments.**

Within our utilization management and care management programs, we have a robust provider linkage process for members needing provider access and availability. Our behavioral health teams do the research for members by outreaching in-network and if needed, out-of-network providers to confirm availability and clinical fit. We then provide our members confirmed availability options. This capability is standard within our behavioral health precertification, concurrent review, Behavioral Health 360 and condition management teams.

We do not schedule appointments for members. Behavioral Health member services, however, is always available to assist in finding providers and offering information. Our customer service team can help with appointment finding and can provide members with a curated list of providers with confirmed availability within three days of request.

### **Emergency appointments**

Clinical triage staff schedule emergency and initial, urgent care appointments for both mental health and substance use.

For routine, non-urgent care, we help members identify appropriate providers in their geographic area. They can then schedule the appointment that best meets their needs.

### **CVS Health Virtual Primary Care™**

Included in your quote is our CVS Health Virtual Primary Care™ program which offers support for common behavioral health conditions. We are committed to providing members with an optimal care experience, which includes transitioning members to the right additional care setting when needed. CVS Health Virtual Primary Care™ takes a thoughtful approach to care transitions to enable members access in-person care, care management and quality-driven specialists when needed. The Care team is equipped to help members navigate these care transitions either through warm hand-offs, proactively scheduling appointments for members or connecting them with quality in-network specialists in their area.

Additionally, members have access to their own health data including visit details and test results through our simple and convenient web-based navigation page. A single patient profile is accessible to providers across sites of care, fostering better communication between providers. With a broader view of care activity, providers deliver personalized health alerts for health screenings as well as lifestyle recommendations. The Care team helps members maintain wellness and resolve critical care gaps before they emerge.

### **3. Please list any lawsuits or settlements against your company in the past three years regarding mental health parity or denial of behavioral claims.**

Aetna Life Insurance Company (ALIC) may be involved in regulatory actions and litigation regarding the administration of our businesses. Due to the size of our business, non-material government, regulatory or administrative investigations, proceedings, complaints, lawsuits or other legal proceedings naturally flow from disputes that arise out of the sensitive nature of services provided by a managed care organization.

ALIC is an indirect wholly owned subsidiary of CVS Health Corporation. We disclose significant regulatory actions and litigations in our parent company's SEC filings. You can find information on Litigation and Regulatory Proceedings in CVS Health's annual and quarterly filings with the SEC.

We haven't been debarred or precluded in any way from doing business in any state. We work diligently and expeditiously to resolve issues that arise as a result of administering or insuring benefit plans for our customers.

**4. Describe your efforts to improve access to behavioral care and your efforts to identify and engage people reluctant to seek behavioral care.**

We want our members to have access to high quality in-network providers. Our constant and continuous goal is to provide members with timely access to a robust network of available, high quality behavioral health providers. To do so, we:

- Encourage providers to offer telehealth services in all 50 states
- Conduct targeted provider recruitments and fee schedule updates, as well as negotiate nonstandard higher rates for providers in areas where there is a specific need
- Increase our network by encouraging members and plan sponsors to nominate providers for inclusion in our network plans
- Increasing national contracts and partnerships with providers in the both the brick-and-mortar space, as well as virtually

**Developing and increasing our network**

We currently have an open network of behavioral health providers and have successfully increased our in-network provider footprint by 21percent in 2024 and over 40 percent since January 2023. Our goal is to provide members with timely access to a robust network of available, high quality behavioral health providers and we now offer 514,000 behavioral health providers nationwide. We have included an attachment titled *BH national network picture (1.1.24 growth).pptx* for state-by state information.

We're also making care more accessible by adding outpatient behavioral health treatment in our CVS HealthHubs in select states. Members can now receive integrated and confidential behavioral health care in a familiar, comfortable setting in their local community.

## Telehealth

We know that our member's need in mental health vary from mild to moderate and encompass all ages. Our overriding goal is to create more access and serve more members. Our focus is on increasing utilization and scale by enhancing our service options.

To do so, we partner with innovative digitally enabled or televideo mental well-being services and we are continually assessing new potential partners. These services allow us to offer alternatives for people who need all levels of care and where traditional counseling may not be appropriate. Our digital partners can also offer mental well-being support in between appointments, as well.

Network providers - For members who need behavioral health services—but can't get to a provider's office—we provide them with access to sessions with a behavioral health provider using their computers, laptops, smartphones or any mobile device. Telemedicine improves access to care, is convenient and allows for continuity of care for our members.

Virtual/digital providers - People's needs in mental health vary from mild to moderate and encompass all ages. Our overriding goal is to create more access and serve more members. Our focus is on increasing utilization and scale by enhancing our service options.

To do so, we partner with innovative digitally enabled or televideo mental well-being services and we are continually assessing new potential partners. These services allow us to offer alternatives for people who need all levels of care and where traditional counseling may not be appropriate. Our digital partners can also offer mental well-being support in between appointments, as well. Please refer to the attachment titled *2025 Aetna BH Televideo-Digital Partners.docx* for more information.

### **Targeted Provider Recruitment**

We use multi-faceted measures of network adequacy for recruitment. These are customized based on local market and individual customer needs. For example, we use geo-access measures of available providers who are actively treating our members. These targeted analyses help focus our recruitment efforts on specific provider types in geographic areas with higher member access to care needs.

We also use internal network data to create customer specific recruitment and retention strategies at no additional charge. We continually identify and recruit out-of-network providers based on data sources such as:

- Account disruption reports
- Out-of-network utilization and single case agreements
- Provider, customer and member feedback
- Competitor network analyses

### **Retention and provider satisfaction**

Our provider recruitment efforts also focus on retention and provider satisfaction. To build relationships and create differentiated value, we offer:

- Competitive reimbursement rates and timely reimbursement
- No prior authorization or clinical review requirements for routine outpatient care
- Access to dedicated Network Management staff to help guide providers through the online enrollment process and provide general administrative support
- Access to the Availity® provider portal (Availity.com), which offers helpful online tools and clinical resources to help manage their clinical practice.

Our efforts have succeeded in that we consistently meet or exceed state network adequacy requirements in all major markets.

## Breaking stigmas to encourage engagement

We understand the motivational issues associated with the stigma and hard work it takes to succeed at behavioral health treatment. We believe that members and their families need ease of access and active support to overcome these challenges. When a member contacts us, we take the time to listen and understand what they need. This occurs at multiple points of entry.

Your Aetna Virtual Assistant (YAVA) is an AI-powered virtual assistant used by Aetna to help members and colleagues by providing information and support through conversational AI. YAVA is designed to understand why a member is calling and deliver the information they need, making customer service more efficient and allowing the BH representatives to focus on more complex issues. YAVA is used in both telephone and chat services to provide accurate responses and improve the overall experience for users.

We strive to connect each member with the benefits and services that make sense for where the member is at that moment. Multiple channels, such as televideo and digital solutions, allow your employees to access care when they need to, wherever they are. This removes the barriers that prevent people from accessing mental health care and that contribute to the stigma.

All our clinical teams (BH and Medical) are trained on motivational interviewing to work through ambivalence and take action to improve health. Motivational Interviewing empowers individuals to explore their thoughts and feelings without judgment, helping to break down the stigma around mental health. By fostering empathy, respect, and personal autonomy, MI creates a safe space where people feel heard and supported—making it easier to take the first step toward getting help and improving their well-being.

Also, within our Behavioral Health clinical teams, we offer:

- Improved engagement through intensive outreach strategies – Performed by our clinical team, outreach actions include connection with the:
  - Member
  - Family, when appropriate
  - Treating providers
  - Co-managing partner (medical nurse, case manager, disability manager, etc.)

- Health advocacy for members to coordinate and work through any co-existing medical and behavioral health conditions
- A unified approach to help members successfully engage in the right treatment, services and resources.

The medical team routinely assesses for behavioral health concerns and when present, guide members to appropriate care and services. The team has direct access to the BH clinicians for consultation and guidance for an integrated approach.

#### Enhanced provider search online experience

We are redesigning our website and offering apps to create a better experience. This will make it easier to navigate and understand available resources and access services more easily. Our technology guides members to the appropriate resource based on their preferences. We are also investigating the use of chatbots and other technology to improve our members' ability to navigate the system. We are launching a search capability that includes BH provider quality performance and member preferences to intelligently match the member to the right in-network provider in a timely manner.

Aetna and CVS Health are actively working to reduce mental health stigma through several key initiatives:

#### 1. Stamp Out Stigma Campaign

- This campaign encourages open conversations about mental health and substance use disorders, aiming to reeducate colleagues and the public on the realities of mental illness and addiction.
- Employees are invited to share their personal stories or "Snapshots" of their mental health journeys, which are featured in the Faces of Mental Health Snapshot gallery and internal communications.
- The campaign also encourages adding #StampoutStigma to email signatures to promote awareness and support for mental health in the workplace.

## 2. Promoting Open Dialogue

- Leadership and colleagues are encouraged to start open discussions about mental well-being, especially during Mental Health Awareness Month and Women’s Health Month.
- The organization highlights the importance of treating mental health as a key part of overall well-being, making it easier for people to speak up and seek help.
- Support groups and confidential counseling are available through programs like Resources for Living, and expanded behavioral health services are offered at MinuteClinic locations and virtually.

## 3. Education and Advocacy

- Aetna provides resources to help colleagues recognize the high prevalence of mental illness and substance use disorders, and to understand that these are treatable health issues—just like any physical health condition.
- The organization encourages everyone to check in with peers, listen without judgment, and advocate for workplace well-being.

## 4. Support and Resources

- Employees and members have access to confidential counseling, work-life support, and crisis intervention services.
- The National Suicide Prevention Lifeline (988) is promoted for anyone in crisis.
- These efforts are designed to create a culture where mental health is prioritized, stigma is reduced, and everyone feels supported in seeking help when needed.

**5. Please describe any specific programs you have targeting first responders and/or the law enforcement population.**

We have offered our First Responder Peer Support program as an optional buy-up.

First responders protect us, but at a cost. They're more likely to face behavioral health challenges because of constant exposure to trauma. To make matters worse, many public safety professionals are not comfortable with seeking help or discussing their behavioral health needs. The results can be deadly. Police officers, firefighters, paramedics and emergency medical technicians face high levels of stress, anxiety, depression and post-traumatic stress. Police and firefighters are more likely to die by suicide than in the line of duty<sup>1</sup>. Additionally, 30 percent of first responders develop behavioral health conditions, which is five times higher than the civilian population rate<sup>2</sup>.

Unfortunately, the stigma associated with support programs can often impede first responders from accessing crucial emotional support. Therefore, we've created our First Responder Peer Support program to help bridge this gap. Our First Responder Peer Support program is a well-being program designed specifically for first responders who typically do not engage with traditional wellness offerings.

**Comprehensive emotional well-being support**

We've partnered with Responder Health to develop our First Responder Peer Support program. Together with Responder Health, we understand the unique needs of first responders and speak their language. The goal is to provide the first responder and their family with the resources and treatment they need to return to the job and their families happier and healthier. To help achieve confidential, personalized support for police, fire professionals and their families, the foundation of our First Responder Peer Support program is a 24/7 helpline and is built on the State of Washington's confidentiality laws, RCW 43.101.425, which are the strongest in the nation for first responders.

When a first responder calls the helpline, they speak with another first responder who is highly trained and has “lived experience”. This is much different than calling a traditional Employee Assistance Program (EAP). We know through direct feedback from first responders that having someone answer their call that has walked in their shoes is absolutely essential. First responders need to talk to someone who understands what they are going through, especially in times of crisis such as anxiety, post-traumatic stress and depression. The helpline is staffed by retired first responders who have gone through program training specifically to help. The 24/7 helpline also gives first responders a path toward therapy for those who need it and who may not otherwise seek it on their own.

To encourage referrals to therapy, first responders in our program are directed to clinicians who have experience working with police, firefighters and emergency medical technicians. This specialized support increases the likelihood that they continue therapy after the first session. To help maintain trust, therapy referrals are always confidential. All referrals are for vetted in-network therapists and treatment centers that have been personally trained and physically vetted to ensure the best treatment outcomes for first responders and their families.

Our program focuses on the whole person and their needs. Individuals are not simply given a website with providers and facilities and left to find their way. Instead, we provide a guided approach and throughout each step in the treatment process, the first responder and their family are the primary focus.

### **Digital tools designed for first responders**

We’ve partnered with Armor Up America to provide a digital app designed with first responders and their families in mind. The app connects members and their families with:

- Direct peer-to-peer hotline access for active and retired workers
- Help for substance use disorder and addiction
- Physical and mental health resources
- Training, education and employment assistance

Through our partnership with Armor Up America, we are giving members and their families the tools to make support simple and personal.

## Supporting engagement

Often times, handing a first responder a flyer is not enough to get them to engage with emotional support programs. Therefore, to engage members in our First Responder Peer Support and to support their continued success, we provide access to:

- Face-to-face engagement with a retired first responder
- Connections between the program and local resources
- An app with content designed for first responders and their families

Through Responder Health we offer a dedicated app for first responders and their families. The app includes self-evaluation assessments and tools, self-help videos and content specific to first responders and their job. The app allows first responders to explore our program on their own time in a safe place. All digital content is designed for the needs of first responders and their families, covering such topics as:

- First responder stress
- Common responses to critical incidents
- Hope and help for family members
- How stress impacts your family
- How to support peers

The app also gives the first responder or their family member an option to call the 24/7 helpline with a button conveniently on the home page.

With our First Responder Peer Support program, we're providing your population with peer support developed by first responders for first responders. By helping to remove the stigma of behavioral health for first responders, we're supporting the physical and mental well-being of our police, firefighters and emergency medical technicians on their path to better health.

<sup>1</sup> Ruderman White Paper on Mental Health and Suicide of First Responders, [www.rudermanfoundation.org](http://www.rudermanfoundation.org), accessed November 2020.

<sup>2</sup> First Responders: Behavioral Health Concerns, Emergency Response, and Trauma, Substance Abuse and Mental Health Services Administration, May 2018.

## Questionnaire – Pharmacy

### 1. Provide a copy of the proposed formulary. Is the proposer's formulary based on the lowest cost and evidence-based guidelines?

Please refer to our attachment labeled Aetna Standard Formulary.

The Pharmacy and Therapeutics (P&T) Committee thoroughly reviews individual drugs and drug classes, using principles defined by the evidence-based medical literature. Our formulary process is developed and managed through the activities of the National P&T Committee. This committee works to achieve a rigorous formulary process and maintain coordinated protocols. Objective and comprehensive reviews are presented to our National P&T Committee for discussion and action. Agents are added to the formulary based on their effectiveness, safety, and therapeutic role (e.g., treatment/prevention) in the management of disease states. The P&T Committee also considers national trends, client needs, and member demographics in conjunction with evidence-based guidelines.

### 2. Provide a list of standard drug exclusions.

Please refer to our attachment labeled Aetna Standard Formulary Exclusions.

### 3. Do prescription drug proposals include Step Therapy, Prior Authorization, and Quantity Limits?

Under the Aetna Standard Formulary you may customize step therapy, prior authorization and quantity limits. We do require the utilization of safety edits and all specialty medications require prior authorization. We charge \$45 per review.

### 4. Does prescription drug proposal(s) include an open or closed formulary?

We consider our Aetna Standard Formulary an open formulary as all exclusions have a formulary alternative.

**5. Will the proposer cover the cost of transferring existing mail-order prescriptions from the incumbent carrier? If so, please provide the file specifications for the data transfer. If not, please outline the Mail Order process.**

No. Aetna shall provide the Customer with an Implementation Allowance of up to \$5.00 per member per year. The Customer can use this allowance to pay for reasonable implementation and enrollment services incurred during the first Plan year. Aetna is including a general allowance up to \$2.00 per enrolled member per year on an Annual basis. The Customer can use this allowance to pay for implementation, audit or communication related expenses along with external data files or feeds.

**6. Will the proposer cover the cost of transferring existing Prior Authorizations and other satisfied Drug Edits from the incumbent carrier? If so, please provide the file specifications for the data transfer.**

No. Aetna shall provide the Customer with an Implementation Allowance of up to \$5.00 per member per year. The Customer can use this allowance to pay for reasonable implementation and enrollment services incurred during the first Plan year. Aetna is including a general allowance up to \$2.00 per enrolled member per year on an Annual basis. The Customer can use this allowance to pay for implementation, audit or communication related expenses along with external data files or feeds.

**7. Please outline the proposer's Specialty Drug process, including clinical support available to members, and if a third-party vendor is involved in these transactions.**

Our specialty pharmacy CareTeams manage all members using our specialty pharmacies on a regular basis to help manage side effects and ensure adherence to their prescribed medication. We see an opportunity for a more holistic approach to management of the most complex – high-cost members. This holistic approach encompasses management of co-morbidities, self-care and other issues that are related to the condition of the member, not just their medications.

Our AccordantCare Specialty nurse management program offers members with rare conditions nurse support with a holistic view, in addition to medication management services through our specialty pharmacy. For rare conditions, our AccordantCare Rare nurses are integrated with our specialty solutions to support members in managing their whole condition and co-morbidities, especially in critical conditions. We provide clinical care focused on the member and the condition vs. the drug dispensed. This can therefore reduce total health care costs and improve quality of life. Members benefit from an integrated specialty pharmacist and nurse experience. This results in timely and coordinated clinical interventions and leads to improved medication as well as care plan adherence.

We are the only specialty pharmacy to provide a truly comprehensive solution by integrating nurse-led care management for rare, complex conditions with our specialty pharmacy services.

Member engagement with our AccordantCare Specialty nurses is a voluntary process to be actively engaged (opt-in). Approximately 40 percent (40%) of members are actively engaged and opt into our nurse care management model. Approximately 65 percent (65%) of those engaged members remain engaged for 10 months or more.

In turn, avoidable ER (Emergency Room) visits and hospitalizations are reduced. The result is a substantial overall decrease in health care costs. In one year, we have seen an 11 percent (11%) reduction in hospital admissions and \$2,158 savings per engaged member.

### **How it works**

With our program, an AccordantCare Specialty nurse works as an integrated part of the specialty CareTeam to address all aspects of the member's condition. This solution is designed to increase clinical education and member engagement leading to improved medication and care plan adherence. By working together as one clinical team, we can provide the member coordinated clinical support and intervene earlier and more effectively which increases member engagement and helps to close gaps in care.

Our specialty pharmacy staff manage the following components for each member:

- Access to specialty medication
- Benefits verification
- Financial assistance coordination
- Injection training coordination
- Education on medication adherence and side effects
- REMS compliance
- Inventory coordination to reduce drug waste
- Refill reminders.

Our AccordantCare Specialty nurses provide critical member support in the following areas:

- Care Optimization – Interventions such as cost of care support, home adaptations and caregiver education.
- Symptom management – Interventions including management or prevention of exacerbations (flares), fatigue, disease progression, pain and cognitive issues.
- Self-Care – Interventions including fall prevention, diet and nutrition support, assessment of motivation or learning gaps.
- Medication Optimization – Reinforce specialty therapy management adherence and interventions related to medication options, cost of medication/site of care support and non-specialty medication adherence.
- Co-Morbidity Management – Interventions including those to address diabetes, depression and heart disease.

#### **AccordantCare Specialty conditions treated**

We have focused on the conditions with associated specialty utilization. We refer to this as our AccordantCare Specialty program. We support the following nine (9) rare conditions:

- Multiple Sclerosis
- Rheumatoid Arthritis
- Crohn's Disease
- Ulcerative Colitis
- Hemophilia
- Cystic Fibrosis
- Systemic Lupus Erythematosus
- Gaucher's Disease
- Hereditary Angioedema.

Our AccordantCare Specialty program allows member-focused clinical care once they fill a specialty medication through one of our specialty pharmacies. This offering is available to self-insured ERISA customers adopting the specialty performance network with zero grace fills and is bundled within the specialty medication pricing. While there is no savings guarantee for this solution, you may achieve up to 11 percent (11%) savings.

**8. Are insulin or other diabetic supplies, such as glucometers, test strips, lancets, etc., considered under the pharmacy benefit proposed or subject to medical plan benefits? If subject to medical plan benefits, please confirm service category.**

To ensure that members with diabetes have the tools to control their blood sugar, we include the following diabetes supplies in all of our plan designs:

- Alcohol swabs
- Blood glucose calibration liquid
- Injection devices including insulin syringes, needles and pens
- Lancet devices and kits
- Test Strips- blood glucose, ketone and urine

We can also offer you a \$0 Preferred Diabetic Benefit. This option entirely removes the member's cost share for certain preferred brands and generics. You may choose whether to offer a \$0 cost share with the following:

- Preferred diabetic supplies
- Preferred insulin
- Preferred diabetic Supplies and insulin

There are considerations to take into account such as claim impact. In addition, we have other programs to support members with diabetes such as Pharmacy Advisor Counseling®, Adherence to Drug Therapy and our Diabetic Meter program. We would be happy to meet with you to determine whether combining this benefit plan with other adherence programs would be the right fit for you and your employees.

**9. Is the proposed pricing offer based on the implementation of any new mandatory mail programs, clinical programs, or plan design changes?**

No.

**10. Is the proposer willing to grandfather existing users of a non-covered drug? If so, please confirm if indefinite or subject to a defined time period (i.e., 12 months).**

No. Prescribing physicians must submit a request to obtain a medical coverage exception for drugs on our prior authorization, step therapy and formulary exclusions lists. Physicians can make this request by:

- Fax
- Telephone
- Password-protected physician website
- e-Prescribing tools.

Because we want members to receive medically necessary treatment, we ask physicians to include the member ID, medical history and any applicable laboratory data with their request.

We grant or deny these medical exceptions based on specific coverage criteria, which health care professionals can access on our website at [aetna.com](http://aetna.com). We communicate the medical exception decision back to the physicians by telephone, fax or e-mail (depending on how we receive the request). If we deny the request, we fax or mail a follow-up letter to the physician and member within two business days (or as otherwise required by state law). This letter states the reason for denial and explains the appeal procedure. Once entered into the system, the information is immediately available to participating pharmacies.

**11. Is the proposer willing to grandfather existing users of medications that require prior authorization (including specialty medications) without having to meet the proposer's requirements?**

Yes. For clients adopting exclusion strategies, some non-specialty and specialty products can be given Prior Use Exemption (PUE) for existing utilizers. A few examples are outlined below. This policy is subject to change based on new clinical guidance. There are two classes that allow PUE for non-specialty drugs: antipsychotics and anticonvulsants. The rules listed below are utilized to determine if a drug in these classes is eligible for PUE: \*Excluded oral drug does not have an AB-rated generic or a generic that is the same chemical entity (tablet vs capsule; capsule vs ODT) \* Excluded injectable drug does not have an AB-rated generic (cannot switch between one IM formulation to another) Some examples of specialty classes that are eligible for PUE are the following: \*Fertility \*Hepatitis C \* Osteoarthritis. \*Certain autoimmune conditions.

**12. What is the generic substitution policy and process for both mail order and retail?**

We will always dispense a generic if available, unless indicated by the prescribing physician.

**13. Does the proposer own the mail-order program? If not, please confirm the Mail Order process.**

Yes. We own and operate CVS Mail Order Pharmacy.

**14. Self-Insured PBM: Does prescription drug proposal(s) ensure that no discount guarantee value will be derived from (1) the additional co-pay value in member pay the difference claims, (2) the AWP value from any compound claims or bulk chemical claims that are labeled and adjudicated under U&C, and (3) the AWP value from pharmacy input errors? All discount guarantees will be true-up on an annual basis, 90 days after the end of each contract year.**

Not confirmed. Discounts and Dispensing Fees contained in this Service and Fee Schedule are guaranteed on an annual basis, subject to the following conditions:

- Discount and Dispensing Fee guarantees are measured individually and reconciled in the aggregate; surpluses in one or more component guarantees may be used to offset shortages in other component guarantees.
- Discount and Dispensing Fee guarantees shall be reconciled and reported to Customer within one hundred eighty (180) days following the guarantee period.
- Discount guarantees are calculated on ingredient cost prior to the application of Plan Participant Cost Share and include zero balance due claims.

The following types of Prescription Drug claims are excluded from the Discount and Dispensing Fee guarantees contained hereinto Compound Prescription claims Direct Plan Participant reimbursement / out-of-network claims Coordination of Benefits (COB) or secondary payor claims In-house pharmacy claims Vaccines (including for COVID) and other COVID testing-related claims 340B claims Claims paid at government required amounts or Claims priced in response to government regulatory requirements

- Retail pricing guarantees exclude claims that reflect the Usual & Customary Retail Price.
- Single Source Generic Drugs are included in the Generic Discount guarantees.
- Only Specialty Products dispensed by a Specialty Pharmacy are included in the Specialty Pharmacy Discount guarantee listed above. Specialty Products dispensed by Participating Retail Pharmacies are not included in any Discount guarantee listed above.

- Aetna has assumed 0.00% in-house pharmacy utilization. Aetna reserves the right to re-evaluate the proposed pricing if the actual in-house pharmacy utilization varies from this assumption.

**15. Self-Insured PBM: Does the prescription drug proposal ensure that the Average Wholesale Price (AWP) for individual claims will not be an annual average, is from one consistent source, and will not, in any way, be calculated, adjusted, or assigned an alternate NDC number?**

Yes. We use Medi-Span.

**16. Self-Insured PBM: Each proposer must confirm that the proposed generic guarantee is based on all generic drugs adjudicated and classified by MONY codes, including single source, and not only MAC'd generic drugs.**

Confirmed.

**17. Self-Insured PBM: Do prescription drug proposal(s) provide an auditable contract with guaranteed price points at the specific client level?**

Confirmed.

**18. Self-Insured PBM: Does the proposer retain any portion of the Rx rebates (retail or mail)? If so, what percentage? If not, are you willing to provide a quote in which all rebates are passed through to the employer?**

Please refer to the Pharmacy Service and Fee Schedule rebate guarantee grids for additional details. Rebate guarantees will exclude the claims noted below; however, any Rebate collected by Aetna for such claims will be passed through to the Customer in accordance with the Rebate terms described herein.

**19. Self-Insured PBM: Please confirm that the proposal includes Rx rebates payable directly to the City of PompanoBeach.]**

Rebate guarantees will exclude the claims noted below; however, any Rebate collected by Aetna for such claims will be passed through to the Customer in accordance with the Rebate terms described herein. Rebate guarantees may be subject to: The adoption of Specialty Guideline Management (SGM) program.

- Plan performance that is materially the same as the baseline data provided by Customer and relied upon by Aetna, including information regarding enrollment and utilization of pharmacy services. The above rebate guarantees exclude:

-Over the Counter (OTC) Claims

- Limited distribution drug (LDD) Claims
- Any other Claim identified as having received 340B program wholesale pricing
- Compound Drug Claims
- Paper or Member Submitted Claims
- Coordination of Benefits (COB) or secondary payor Claims
- Vaccine and vaccine administration Claims
- COVID treatment Claims
- Claims for products with coverage or a plan design mandated by the government
- Claims approved by Formulary Exception
- Rebate guarantees assume Advanced Control Specialty Formulary.
- Specialty Rebate Guarantees will only apply to Specialty Product Claims dispensed at participating Specialty Pharmacies when mandatory Specialty Pharmacy fulfillment is instituted herein, subject to any exceptions set forth herein.
- Brand drug claims in the HIV therapeutic category are included in the retail rebate guarantees.

**20. Self-Insured PBM: Each proposer must confirm that the client will receive all quarterly formulary rebate and reconciliation payments within 90 days of the quarter's close. If "Not Confirmed," indicate the number of days that you will pay quarterly rebates within.**

Not confirmed. Rebates will be distributed on a quarterly basis by claim wire credit. Rebate collections are paid quarterly one hundred and eighty (180) days after the quarter ends. Rebates are calculated and paid in accordance with the terms and conditions of this Agreement. Earned Rebates are distributed in March, June, September and December each contract year.

**21. Self-Insured PBM: Do single-source generics fall within the proposer's generic or brand-name tiers? How are single-source generics classified when projecting discounts by tier?**

Single Source Generic Drugs are included in the Generic Discount guarantees.

## 22. Please outline details of the proposer's Weight-Loss medication program(s) available.

Metabolic health is an umbrella term for the intersection of diabetes and obesity. Poor metabolic health can have a direct correlation to a person's risk for heart disease, diabetes, and stroke- also leading to significant health care costs for both members and payors. We take a comprehensive approach, offering a suite of solutions aimed at improving outcomes by treating the entire patient, reducing costs, and providing the flexibility to design a solution that meets your goals and objectives.

The use of glucagon-like peptide 1 receptor agonists, or GLP-1s, has skyrocketed over the past few years, and the upward curve shows no sign of slowing: The category could reach more than \$77 billion in global sales by 2030.<sup>1</sup> These therapies are highly effective. However, they are also costly.

We will support you in developing a thoughtful, data-driven approach to meet your specific needs focused on three key elements:

- **Coverage** options for GLP-1s
- **Cost** management options based on coverage
- **Care** management solutions, which include:
  - Weight Management
  - Diabetes Management (Transform Diabetes Care/TDC)
  - Deprescribing (DeRx)

### Coverage options for GLP-1s

Coverage approaches to GLP-1s are not one-size-fits-all. Some plan sponsors may choose to offer coverage that fully aligns with U.S. Food and Drug Administration (FDA)-approved labeling and clinical compendia-supported uses. Others may want to exclude coverage of GLP-1s for weight management or put in place more stringent coverage requirements for the weight management class.

Coverage decisions should take into account the health outcomes and total cost of care impact that weight management can have in preventing chronic condition onset or progression. Treating obesity can help reduce downstream pharmacy and medical spend. Pharmacy benefits can also be an important talent attraction and retention tool in today's competitive labor market.

Plan sponsors may assess their coverage options depending on the nature of their employee population. For example, those in industries that experience high turnover may have lower vested interest in long-term outcomes and may opt for a more stringent coverage approach, with rigorous utilization management (UM) levers in place.

### Cost management options based on coverage

Our multifaceted approach to cost management includes leveraging our scale and market expertise to negotiate low net cost and using formulary design to prefer low net cost products. Plan sponsors can choose plan design and formulary levers that align with plan goals, including a 100-percent member copay option and plan design with category exclusion. Select formularies also include new-to-market review, which evaluates appropriate use of drugs according to FDA-labeled indication and encourages use of comparable formulary drugs.

### Utilization management strategies

If your plan design includes coverage for GLP-1s, we can help ensure appropriate utilization through intelligent controls, including:

- **Prior authorization (PA)** to help ensure utilization is clinically appropriate at the onset of therapy and throughout treatment.
- **Step therapy** requiring members with type 2 diabetes to try metformin before progressing to a GLP-1.
- **Quantity limits** to help ensure dosing does not exceed recommendations.
- **Weight Management UM Bundle** that allows for comprehensive drug class management by automatically updating and/or adding new UM criteria, when available.
- **Smart logic PA** to help prevent coverage of off-label utilization while minimizing member impact.<sup>2</sup>

### *Tailor coverage of new weight management drugs from day one*

The Weight Management UM Bundle helps ensure clinically appropriate and cost-effective coverage for weight management medications. It automatically applies evidence-based UM criteria so you can manage coverage for new agents as soon as UM criteria become available.<sup>3</sup>

The bundle currently includes criteria for:

- Contrave
- Qsymia
- Saxenda
- Wegovy
- Xenical
- Additional weight management agents<sup>4</sup>

UM criteria are supported by medical evidence and require documentation and drug-specific quantity limits.

**23. Please also confirm the City of Pompano Beach's ability to accept or reject proposed Formulary changes.**

The offer in this proposal is based upon your alignment to our standard formulary. For a custom formulary, additional administrative costs may apply, ranging from \$50,000-\$100,000 depending upon the level of customization.

**Questionnaire - Stop Loss**

**1. Please confirm the proposed quote is firm. If not, please provide details as to why.**

The proposed quote is illustrative and not firm. The quotation offer becomes firm when claims are updated within 120 days of the effective or renewal date and a final review of large claims is completed. The customer must accept a firm offer within 30 calendar days from the date of delivery of the quote. If the customer doesn't accept within 30 calendar days, we reserve the right to request updated underwriting data, which may alter rates or the terms of the quote.

We require a system-generated claim detail report for Rx claims which includes

- Employee name
- Employee social security number
- Claimant name
- Claimant relationship to employee
- Claimant date of birth
- Incurred date of claim
- Paid date of claim
- Paid claim amount
- Name of drug
- Name of provider

This report should show each claim individually, as well as subtotals for each claimant.

**2. Please confirm the proposed quote contract terms.**

This stop loss proposal is illustrative. Please see the stop loss caveats for full terms and conditions of our offer.

**3. Please confirm the proposal does not include lasers.**

Lasers remain To Be Determined until the quote is considered Firm.

**4. Please confirm the proposer's process for inclusion of lasers, if applicable, at renewal.**

Our approach for dealing with ongoing large claims at renewal depends on various factors: amount of the ongoing large claims, case size, expected Stop Loss renewal premium, and specific deductible level. Aetna typically offers more than one renewal option for dealing with this situation. These options would include; adding a premium rate load, coinsuring the ongoing large claim at other than 100 percent, incorporating a combination of risk share and premium load, an aggregating specific deductible option and/or a family individual deductible option.

We will not offer, as the sole renewal option, a quote which lasers a claimant that had not previously been lasered. Upon request, we will review any first year lasered claimants in advance of the renewal year and re-evaluate their risk and the need to continue to laser those individuals.

**5. Please detail data requirements in order to process reimbursements.**

When we're the claims administrator, the customer must provide eligibility information for purposes of making claim payments for their plan. When sold together, this eligibility information is also used to determine coverage under the Stop Loss policy. The customer determines eligibility for their plan, as required by ERISA, and subject to the terms stated in the customer's plan document. Enrollment exceptions made by the customer that aren't as stated in their ERISA-required plan documents, aren't covered by Stop Loss.

**6. What is the time frame for reimbursements once the claim information is submitted for payment? Do you offer Advanced Funding on claims reimbursements at no cost to the client?**

When we're the claims administrator, the underlying self-funded medical plans are fully integrated with our standard Stop Loss features at no additional cost. Funding is immediate and claim report submissions aren't required. Eligible claim expenses that exceed the individual Stop Loss amount are immediately funded by Aetna, on the same day the claim payment is issued. The group has no out-of-pocket expenses for these specific claims.

Circumstances under which funding isn't immediate include non-standard Stop Loss features, claim run-in, claim run-out and claims paid by third party administrators. Advance Funding or Special Cash Flow Assistance isn't currently available in these situations.

**7. Please confirm that the proposer will base stop loss coverage reimbursements on the 'Eligible Expenses' as defined by the medical ASO plan document.**

Stop Loss covers eligible claim expenses:

When paid according to the plan of benefits; and  
In accordance with Aetna's Clinical Policy Bulletins (CPBs); and  
Except as otherwise excluded by the policy or legislation.

Stop Loss does not cover benefits when coverage or eligibility is made at the plan sponsor's direction but that we determine are not payable under the plan, according to our standard provisions, Clinical Policy Bulletins, and claim settlement practices, or that are in excess of the reasonable and customary charge. A complete list of our Stop Loss exclusions is available upon request. For this reason, Aetna will only cover benefits paid when Aetna is the claim final fiduciary for paid benefits and the appeals process.

Department of Insurance (DOI) and Department of Labor (DOL) regulations mandate that Stop Loss coverage be applied uniformly, consistently and without bias. We comply with these requirements through our E&I (experimental & investigational) and medical necessity definitions and exclusions. Our Clinical Policy Bulletins determine this coverage, just as they do for commercial insured business, preventing discrimination and ambiguous coverage determinations. When we are the claims administrator, we have the information necessary to support coverage determinations and eligible claim expenses apply to Stop Loss, automatically.

**8. Proposers must confirm Stop Loss coverage is also quoted for Retirees Over 65 (Medicare) remaining on a Group Medical plan through the City of Pompano Beach. Does the proposal exclude any member population included in the census?**

Confirmed. No member population excluded from the stop loss.

**9. If the proposer is awarded the Stop Loss insurance contract, please confirm if the policy is guaranteed renewable.**

Confirmed. We offer all renewals on a true paid contract basis, providing maximum coverage with no gaps due to differing contract or policy periods.

We determine the offering of run-in coverage on a case-by-case basis. There may be a limit on the number of months of run-in that we are willing to quote, and we do limit the liability we assume for run-in claims. Stop loss reimbursement for eligible claims occurring during the run-in period is handled on a delayed year reimbursement basis. Final settlement with regard to the run-in claims is made at the end of the policy year or after the end of the run-out period, if run-out coverage is also being provided.

Our renewal Stop Loss policy operates on a policy year, paid claim basis. Claims that cross policy periods are covered by the subsequent year's policy. We don't pay the same claims under multiple policies. We do, however, apply claims overturned by an Independent Review Organization in accordance with HIPAA requirements.

**10. Upon underwriting approval, does the proposer offer a maximum renewal rate cap on specific rates?**

A renewal risk cap has not been included in our stop loss proposal. Upon request we will provide a quoted option with a renewal risk cap.

**11. Does the proposer have an aggregating specific deductible option available that represents a dollar-for-dollar premium offset to share risk?**

Aetna offers an Aggregating Specific option, which offers a reduction in premium in exchange for the customer assuming more risk or in lieu of lasering.

**12. What aggregate corridors are available for consideration?**

115%, 120%, 125%

## Questionnaire - Implementation and Billing

### 1. Please provide a brief description of the implementation process, including requirements and timeline.

We use custom tools, a team approach and survey feedback to keep improving the quality of our implementation process. In this way, we continue to build, improve, support and maintain high-performing implementation teams that truly differentiate us in the marketplace. In 2025, our overall customer satisfaction rate was 96 percent which is a strong testament to our commitment to you.

The cornerstones of our implementation approach are:

- Experience — We provide an experienced team of subject matter experts
- Collaboration — We work strategically with your internal team and vendor partners
- Customization — We use versatile project plans and management tools
- Effectiveness — We develop result-oriented plans and execute flawlessly
- Quality — We strive for continuous improvement in our processes and procedures

Your implementation is more than simply hitting the right dates. It's about making the change easier. We remove barriers, offer timely solutions and stay by your side throughout the implementation process.

#### Supporting you every step of the way

Our high-touch approach includes a team of technical experts and specialists. They consult with you to implement the chosen programs and provide ongoing service. Likewise, we ask you to identify a team made up of members from your financial, benefits, information technology and human resources departments, as well as other business areas, as needed.

We find that the team concept increases accountability and responsiveness. It also provides the highest level of customer and member satisfaction.

### **Custom implementation tools**

We use custom project management tools to meet and exceed your expectations for a smooth transition. During the process, we illustrate the products, programs and services you choose on our detailed Implementation Management Plan. This plan identifies members of the implementation team. It also establishes target completion dates for all associated activities.

We use an implementation tracking tool to track open items to resolution. We regularly update and distribute this document to the implementation team to keep team members on track and informed of the project's progress. The document is part of our "all-in-one" approach and includes all relevant information and project details in a single spot.

### **A comprehensive and phased approach to implementation**

We use a phased approach to your implementation so that all aspects of the project are thoroughly accounted for, including:

#### Phase 1 — Discovery

In the discovery phase of your implementation, we review plan proposal commitments, obtain preliminary information and form our internal implementation team.

#### Phase 2 — Define

In the defining phase of your implementation, we conduct a strategy meeting, assign technical resources, define roles and responsibilities, as well as conduct an internal kick-off meeting.

#### Phase 3 — Implementation

In this phase of your implementation, we conduct an implementation meeting with you, confirm your vendor partners, review your implementation project plan and milestones, as well as schedule status meeting calls.

#### Phase 4 — Plan setup

In the fourth phase of your implementation, we finalize plan design, account structure, eligibility and coding, confirm any vendor coordination requirements, set up systems according to the benefits and programs you select, train member service center team and support open enrollment activity.

Phase 5 — Go live

To successfully go live, in this phase of your implementation, we complete plan testing, load eligibility and enroll members, mail ID cards and release claim hold for processing.

Phase 6 — Post implementation

In the final phase of your implementation, we monitor remaining tasks, complete a signoff call with your team and our team, as well as transition responsibilities and any open activities to the account team.

We also send out surveys to you and the account team that ask for comments on the process, as well as feedback on the implementation manager. The survey results tie directly back to the implementation manager's performance rating.

Please see our *Implementation Solutions* located within the Exhibits section of our proposal response.

**2. Please confirm the proposer is flexible to modify the standard contract language.**

Confirmed.

**3. Please confirm the proposer is willing to waive the binder payment requirements.**

Not applicable. We do not require a binder payments for fully insured or self-funded contracts.

**4. Please confirm the proposer is willing to accept a self-bill for the proposed line(s) of coverage.**

Confirmed. Please see the information below for the variations based on coverage lines and funding types.

**Fully insured medical and pharmacy**

For list and summary billing with our fully insured medical and pharmacy plans, we accept a customer's version of our billing statement if it contains the required information: social security number, last name, first name, premium and tier. Additionally, the customer's billing consultant must approve it prior to use.

We accept premium rosters submitted electronically in a Microsoft Excel file. We don't accept paper files.

An example of the acceptable format is provided below:

Social Security Number	Last Name	First Name	Premium	Tier
123-45-6789	Smith	John	236.50	Couple
123-45-6789	Johnson	Jim	197.50	Single
123-45-6789	Hare	William	-327.00	Family

**Self-funded medical and pharmacy**

For our self-funded medical and pharmacy plans, your version of our service fee billing statement must contain the following required information: customer number, plan sponsor unique ID number (PSUID) and bill package (BP), due date, product code, list of member names, rate and the total fee due.

Additionally, your billing consultant must review and approve the self-billing statement prior to use.

### **Self-funded stop loss**

Stop Loss premium is billed monthly. We may bill you electronically and you may pay premium due to us electronically. If you aren't billed electronically, you must send your premium to us at the address shown on the invoice on or before the premium due date. Premium is due on the premium due date.

All premium payments must be made in U.S. dollars no later than 30 days after the premium due date. If we haven't received the premium due by the due date, the policy automatically terminates without further notice to you and all rights to benefits under this policy end. Premiums are due for any period the policy was in force. Refer to the termination section of this policy.

#### **5. What is the proposer's standard billing snapshot date and grace period for payment?**

We expect the monthly payment by the due date. We standardly allow a 31-day grace period following the due date.

#### **6. Would you allow a grace period after the due date of 45 days for payment of an invoice?**

Confirmed. We expect the monthly payment by the due date. We standardly allow a 31-day grace period following the due date. However, we will allow a 45-day grace period following the due date.

## Questionnaire - Renewal Planning and Additional Fees

**1. Is the proposer willing to provide a renewal offer at least 120 days prior to the renewal effective date?**

Confirmed.

**2. Are any of the rates proposed contingent on any additional information? If so, please disclose.**

Our proposal assumes that prescription drug benefits and stop loss are included and will be provided by Aetna. In the event that Aetna is not selected as the pharmacy or stop loss vendor, we have included buy up charges associated with accepting feeds from a third-party vendor and integrating the data into the medical management program.

**3. What additional services are available and at what cost?**

Please see the financial proposal for a suggested list of additional programs and services available for additional costs.

## Questionnaire - Enrollment & Implementation Technology

**1. Does your company (or third-party) process electronic eligibility files via automation, or are manual steps necessary? If manual steps are required to process files, please explain this process and its impact on processing time.**

We can accept and process eligibility data in any of the following methods:

- Internet-based enrollment system - EZenroll®, our online enrollment application, you can perform several enrollment functions online, including additions, changes, terminations and PCP selection.
- Internet-based eligibility transfer solution - SecureTransport™ allows you or your vendor to transmit eligibility files to us during open enrollment and for ongoing updates. SecureTransport is a trademark of Axway used under license.
- Electronic transport method - You can submit eligibility through any number of electronic transport methods. Depending on the method used, we can accommodate secure Internet FTP and EDI ANSI X12 formats.
- e.List - We accept an e.List formatted as an Excel spreadsheet populated with eligibility data to submit initial enrollment. We scan the spreadsheet into our systems and mirror an electronic file, eliminating manual intervention.

We provide you with the options mentioned above so that you have choices that match your needs and preferences.

### **Manual intervention**

Your designated eligibility consultant can assist you with manually enrolling a member on an emergency basis. Manual updates appear immediately in the eligibility system. Our system overwrites any ad hoc changes made to our system if the next regular transmission doesn't include the new information.

### **2. Does your company outsource the processing of electronic eligibility to a third-party? If so, please provide the company name.**

No. We do not outsource the processing of electronic eligibility to a third-party. Our eligibility system is the Member Enrollment Application (MEA) system. The eligibility aspect of our MEA interfaces with policy entry, claims and pharmacy management systems.

### **3. Please specify if your company (or third-party) accepts the HIPAA 834 5010 file layout as well as all other file layouts accepted for automated enrollment. Please provide applicable coding supplements and other applicable file specification documents.**

We comply with the HIPAA Electronic Transactions Regulations (version 5010) and support the American National Standards Institute (ANSI) ASC X12N and NCPDP (version D.0) standard formats. Additionally, Aetna is Phase III certified with the Council for Affordable Quality Healthcare's Committee (CAQH) on Operating Rules for Information Exchange® for all our transactions. Our transactions demonstrate IT system or product operating in conformance with a specific rule set(s) of the CAQH CORE Operating Rules. The NCPDP standard formats are used by retail pharmacies for drug claim transactions.

Among current Aetna-supported electronic transactions:

- 270/271: Eligibility/benefit inquiry and response
- 276/277: Claim status inquiry and notification (including document attachment)
- 278: Referral/precertification request and response
- 275/277: Precert Document Upload (Attachments)
- X12N 275 6020 version EDI Claim Attachments (In production with Change Healthcare - phased roll-out to Availity, PnT Data, Waystar)

- 820: Health plan premium payments (ANSI ASC X12N)
- 834: Enrollment and disenrollment in a health plan (ANSI ASC X12N)
- 835: Claim payment and remittance (electronic remittance advice (ERA))
- 837: Claim/bulk encounter submission (professional, institutional, dental)
- 837: Coordination of Benefits
- NCPDP D.0: Pharmacy claim submission

We recommend that you or your eligibility vendor provide electronic eligibility in our preferred industry ANSI 834 file format. This format allows the most flexibility in meeting your eligibility reporting needs. We can also accept an electronic eligibility file in our proprietary 2000-byte format or in our Consolidated Eligibility Format (CEF) file format. Any customization to our standard format is evaluated on a customer specific basis. If approved, charges to establish and support the customization generally apply.

**4. What is your company's (or third party's) standard processing time for electronic eligibility to be updated in all applicable internal systems (eligibility/claims/billing/etc)? If time varies, please specify for each system.**

We work with you during implementation to determine the methods available to obtain initial and ongoing eligibility. These discussions include medium, frequency and transaction types. We can accept transaction-only electronic files or full in-force files twice a week, weekly, twice a month or monthly. We prefer full in-force and weekly files. We accept transaction-only files if we receive at least one full file submission each quarter. We upload electronic eligibility files received in the proper format automatically to our mainframe system. We don't accept paper enrollment forms.

Once we upload the eligibility information to our mainframe system, we notify your designated eligibility consultant to review an edit of the file online. The eligibility consultant reviews the file within 48 hours and updates the eligibility system if there are no other data quality concerns. Updated information appears in our eligibility and claims system immediately. Eligibility files that are submitted in an incorrect format do not automatically proceed to the edit stage and your eligibility consultant is notified. Your eligibility consultant is responsible for working with you to resolve any errors, data quality or formatting issues that may arise.

**5. Will your company (or third-party) provide confirmation notification to the group when files are processed? Please provide details related to this notification process (email, requirement of group login into the company website, etc.)**

Your designated eligibility consultant notifies you when we receive and upload eligibility files. Once we load the eligibility files into our system and create reports, the receipt of the reports is your additional confirmation of successful processing.

**6. Please provide implementation time (in days) for the initial set-up of automated enrollment (electronic eligibility) of an established group with your company.**

As your current benefit program administrator, we would assume that we would continue to use the eligibility process we had in place today. However, should you want to change to a different enrollment method, we would recommend sending test eligibility files at least 90 days prior to the effective date. This allows time for any adjustments to the file and subsequent testing prior to sending a full eligibility file. We recommend having a full eligibility file 30 days before the effective date.

**7. Please provide implementation time (in days) for the initial set-up of automated enrollment (electronic eligibility) of a new group with your company.**

We recommend sending test eligibility files at least 90 days prior to the effective date. This allows time for any adjustments to the file and subsequent testing prior to sending a full eligibility file. We recommend having a full eligibility file 30 days before the effective date.

**8. Please provide the set-up time needed for changes to file structure, plans, funding strategy, and platform changes for an established group within your company. What alternative options does your company provide to receive enrollment should these changes cause a delay in the setup of the EDI process?**

For established customers the time it takes to implement plan or program changes varies depending on your choice of products, services and clinical model. We generally recommend a lead time of 120 days prior to the effective date for a smooth transition.

New member coverage is active immediately after a viable Electronic Data Interchange (EDI) file loads into our eligibility system. Common problems during implementation, and the first few months of the plan, may include delays in receiving required implementation documents or files, late enrollments and data errors. We work closely with you throughout the implementation to stay on track with key milestones.

To ensure timely and successful enrollment, our team helps you plan, coordinate and conduct enrollment activities that help your employees understand their new benefits program.

In addition, the assigned eligibility consultant works with you to review eligibility submission options, set dates for the submission of eligibility information and establish a target date for the production and mailing of member ID cards.

**9. Please provide the file testing time frame (in days) for initial set-up and structure changes.**

For a group new to Aetna, the time it takes to implement a plan varies depending on your choice of products, services and clinical model.

We generally recommend a lead time of 120 days prior to the effective date for a smooth transition.

We develop an implementation schedule that outlines the tasks associated with each portion of the project. It provides a scheduled start and completion date for each task and helps keep team members on track.

**10. Please provide the standard time frame required to process files, generate, and mail member ID cards. What options does the group have if ID card delivery is delayed beyond the plan's effective date?**

To make ID cards available on or before the plan effective date, we need the clean electronic eligibility file at least 15 business days before the plan effective date.

**Timeframe to mail member ID cards**

Our goal is to create and distribute 99 percent of ID cards within two business days of receipt of clean eligibility data. In 2024, we printed and mailed 99.96 percent of ID cards within two business days. Our vendor performs a quality review before releasing ID cards.

We mail ID cards first class through the United States Postal Service directly to the member's home. If the member's address isn't present or valid, we mail the ID cards to you for distribution. We produce our ID cards on laminated paper.

Members can request a new printed ID card on our member website or by calling Member Services. Members requesting that we mail a replacement ID card receive it within 7 to 10 business days from when we receive a request.

Mailing delays

We provide a digital image for replacement ID cards to members. Members can view and print the digital ID card on our member website at **Aetna.com** approximately 24 hours after the eligibility information updates.

We provide ID cards at no additional cost to you unless you request suppression of all digital cards. If you request that we print all ID cards, we charge for the printed cards that'd have been digital.

**11. If the group utilizes a third-party vendor for data analytics, will you cover the \$2,500 set up fee and the \$0.65 PEPM for the monthly data analytics interface?**

Confirmed.

**12. Please confirm your company will provide ongoing file feeds to multiple third-party vendors (i.e., PBM, Stop Loss, and Data Analytics) at no cost to the group?**

Confirmed. We offer weekly, biweekly or monthly feeds of medical, dental and CVS Caremark® prescription drug claim data. Please note, additional fees may apply and vary depending on the frequency of the feeds and customization requirements. Files are available within three to five days from the end of the reporting period. A signed confidentiality agreement is required prior to the release of this information.

## Questionnaire - Data and Reports

**1. Describe the reports you will provide regarding the utilization and claims associated with the employee benefits program(s) you are proposing. Please indicate in your description if any of the reports would be provided at an additional cost over the fees associated with the programs.**

We provide a variety of comprehensive reporting packages that allow you to evaluate plan and program performance, monitor cash flows and identify cost and utilization trends. These standard reports are available to you at no additional cost. Availability of certain reports is dependent upon your plan of benefits. We have outlined the types of reports available to you, including the frequency.

### Utilization

We offer a state-of-the-art data and analytics experience, to encourage data-driven decision making for optimal plan performance and best well-being. Secure access to Analyze-Rethink-Transform (ART), unlocks a powerful, collaborative, browser-based analytic platform to be used by customers, our account teams and customer-approved advisors, brokers and consultants.

ART is designed for intuitive on demand data investigations into cost drivers, utilization, population health and outcomes. Analytic pathways reveal meaningful insights into opportunities for plan improvements and cost savings, using a self-service business intelligence approach. This means users may explore vast amounts of data using an intuitive, point and click environment specifically designed to support analytic investigations.

Many standard, preformatted reports can also be run on demand with choices of filters such as account structure, age band and network. The report package is produced on a rolling 12-month incurred claim basis, and includes statistics related to plan elements such as demographics, trends by cost category, network usage, most frequently utilized services and providers, high-dollar claims and disease incidence. We deliver these reports to you through our secure Internet report delivery system, which is a standard component of our administrative services. The preformatted reports are in Microsoft® Excel and easily downloaded monthly for review, analysis and electronic communication. You can also create your own reports on demand by selecting various time periods, account structure, product combinations and claim basis including incurred or processed. Data is updated monthly.

### **Annual accounting**

For self-funded and fully-insured retrospective plans, at the end of each contract period, we provide a look-back at the year to determine an overall financial balance. The package includes detailed and summary exhibits of service fee payments, claims and reserve charges and administrative expenses. We provide the accounting 120 days after the end of the policy period. The reports are available electronically, usually in Microsoft Word format.

### **Claims**

For self-funded plans, we provide you with a monthly Claim Detail Report claim report, in a Microsoft Excel format, 10 business days following the end of the reporting period. The Claim Detail Report provides a claim line level of financial information that provides a breakdown of claims information for all funding request activity for that particular reporting month. The report is made available through a secure email.

### **Banking**

For self-funded plans, the funds summary report package provides a listing of monthly wire transfers, which allows you to reconcile claims payments with wire transfers. The reports are available to you through our secure email no later than the 25th of the following month for the prior month's activity.

**2. What is your proposed frequency of reporting on utilization experience? Is there a charge for analyzing utilization data?**

As a part of our standard reporting, we provide you with online, on demand, utilization reporting. Data updates occur 30 days following the end of the reporting period with a 2-month lag time.

Additionally, we can provide you with email ad hoc reporting as needed. When requested, we prepare the reports within three to five business days.

**Analytic costs**

For our fully insured plans, your account team works with our Plan Sponsor Insights (PSI) consultants to support analytic consultations and ad hoc reporting while making the most of the consultative hours available to you.

For our self-funded plans, customers with 100 or more enrolled subscribers who are looking for support beyond our standard reporting have access to our regionally aligned Plan Sponsor Insights (PSI) consulting group and 10 hours of consultative support. This service includes ad-hoc reporting. We quote highly complex requests on a fee-for-service basis.

**3. How often are claim audits conducted, and what percentage of claims are audited? If you use a third party to audit claims, please disclose the name of the auditor.**

We conduct our claim audits internally using stratified audits. We don't audit claims using a fixed percentage. In keeping with industry best practices, a sampling of claims is randomly selected from within each stratum. On a quarterly basis, we typically audit over 300 claims per stratified audit.

#### 4. How do you identify fraudulent claims, and how will you notify the City of Pompano Beach?

We subscribe to a zero-tolerance policy on health care fraud. As a founding member of the National Health Care Antifraud Association (NHCAA), we have been an industry leader in the fight against health care fraud.

Alerts built into our claims system identify potential fraud before the claim is paid. When we suspect fraud and abuse, we create a case and assign a Special Investigation Unit (SIU) investigator. Our SIU is comprised of more than 160 employees and is responsible for our health care fraud, waste and abuse (FWA) program. When the investigator has enough evidence to allege that it is indeed fraud and abuse, we place a flag on the provider's file. This triggers an edit that alerts the claim processor to the investigation. Only our SIU team members can place and remove fraud flags in our system.

If we've already made a payment that we later learn to be either incorrect billing or outright fraudulent, our SIU investigators work directly with the providers to recover the money.

The New York State Insurance Frauds Bureau referred to our SIU as "the gold standard for SIUs." The unit recovered approximately \$20 million in fraud payments in 2025. But it's much more than that. The specialists in our SIU also work hard to stop fraud and abuse in its tracks before payment is made. In 2025, their efforts helped us catch more than \$1.1 billion in incorrect or fraudulent billing before the payment was made. These are actual figures, not forecasted or assumed amounts.

The major components of our program include:

- Prevention – Prepayment claim review and routing to prevent fraud, waste and abuse and other improper payments.
- Detection – Proactive data analysis to identify providers where behavior differs significantly from their peers or other potential fraudulent billing behaviors. Dedicated team members are responsible for data mining and case triage.
- Investigation – Thoroughly exploring all of a provider's billing and practice behaviors, not just a single claim or issue. Credentials of our investigative team include certified coders, accredited health care fraud investigators, certified pharmacy technicians, nurse professionals, and a medical director.

- Recovery – Aggressive pursuit for full recovery of money lost due to fraud, waste and abuse. We address the issue directly with the suspected provider or member, and file civil action, if necessary, when it makes sense to do so. We also educate providers where appropriate.
- Training – Mandatory annual fraud, waste and abuse and compliance training for all employees, business associates and delegates.
- Reporting and Compliance – Compliance with all mandatory state and federal fraud, waste and abuse reporting requirements. If an investigation suggests the intent by a member to defraud, we notify the customer through the account representative for self-funded customers upon completion of the investigation.

The SIU maintains a 24-hour toll-free hotline (**1-800-338-6361**) for fraud reporting and receives more than 2,000 calls per year.

#### **5. Describe the process for identifying and paying claims that may be subject to subrogation.**

Our subrogation processes vary based on funding type.

##### **Fully insured**

We use the Rawlings Group dba Machinify, an experienced national vendor of third-party recovery services, headquartered in Louisville, KY, as our subrogation vendor.

Subrogation is a standard component of the fully insured contract, and no additional fees apply. Our subrogation program is only administered on a "pay and pursue" basis, since to subrogate, we must first incur a medical expense.

We send paid claims data to the Rawlings Group for investigation. Using predictive analytics, the Rawlings Group mines paid claims data and member eligibility data using a proprietary set of diagnostic codes to identify trauma-related treatments. The Rawlings Group's proprietary analytics, along with using multiple data sources has reduced our need to involve the member in the investigation process. As a last resort, where information isn't available from other data sources, members are sent up to five inquiry communications that include a brief questionnaire asking about their treatment. The Rawlings Group opens a file and pursues all avenues of recovery upon confirmation that a recovery situation exists. Subrogation opportunities may also be brought to our attention when we are asked to respond to a subpoena in a member's tort lawsuit requesting records of payment.

The Rawlings Group remits funds and reports to us twice a month. We don't provide subrogation recovery reports to fully insured customers. We retain all net recovery dollars for fully insured plans.

### **Self-funded**

For self-funded plans, the Rawlings Group dba Machinify is our subrogation vendor. They're an experienced national vendor of third-party recovery services headquartered in Louisville, KY.

For a self-funded group electing to use Rawlings, the account manager makes arrangements for subrogation and reimbursement services. The account manager is responsible for completing applicable forms and providing them to Rawlings. The finalized Summary Plan Description (SPD) must include subrogation and reimbursement language before pursuing any recoveries.

The following provides an overview of The Rawlings Group's file identification, investigation and recovery processes.

### Identification

- Using predictive analytics, Rawlings mines paid claims data and member eligibility data using a proprietary set of diagnostic codes to identify trauma-related treatments.
- Rawlings' proprietary analytics, along with the use of multiple data sources, reduces our need to involve the member in the investigation process.
- As a last resort, where information isn't available from other sources, members receive up to three inquiry letters that include a brief questionnaire asking about their treatment.
- Members have three ways to respond to Rawlings' questionnaire:
  - Call a toll-free number answered by experienced analysts
  - Return their completed questionnaire in a postage-paid reply envelope
  - Visit [TRGClaimsInfo.com](https://www.trgclaimsinfo.com) and complete the questionnaire online
- Self-funded customers have an option to enroll in a "Partnership Program" with Rawlings to receive monthly detailed non-cooperation reports to encourage cooperation among employees and dependents.
- Subrogation opportunities may also be brought to our attention when we are asked to respond to a subpoena in a member's tort lawsuit requesting records of payment.

### Investigation

- Investigations are assigned to analysts organized by client-specific teams who are supported by team attorneys.
- Analysts define a strategy based on every possible source of recovery and place all parties on notice of your claim.
- Analysts manage files on their proprietary software. Some of the many features include:
  - An automated diary system that allows analysts to record the details of all file activity and share these with other team members collaborating on the file.
  - A tickler system that automatically prompts analysts to plan effective follow-up for each file.
  - Automated special-handling notifications (group restrictions).
  - A library of letters and notices approved by Rawlings' legal team.

### Recovery

Subrogation recoveries are remitted from Rawlings to Aetna via a bulk wire and recoveries are credited to an individual customer at the claim level through their wireline account. The customer sees a credit for the gross recovery, a charge for Rawlings' fee and a separate charge for any administrative fee charged by Aetna on their claim detail report. Amounts paid but not recovered through subrogation remain charged to your plan. Subrogation recoveries are remitted and processed twice a month and reports are provided quarterly.

We continue to pay the member's eligible expenses during the investigation. Rawlings generally doesn't involve you in the investigation. If the investigation and recovery efforts warrant, Rawlings pursues a third party through legal action. If the member has already obtained a recovery, Rawlings may, where appropriate, pursue litigation against the member.

## 6. Will there be online access for claim reports by the City of Pompano Beach and Gehring Group?

Confirmed. As mentioned previously, we grant secure access to Analyze-Rethink-Transform (ART), our powerful online, self-service, analytic platform for customers, trusted account teams and supporting resources, and customer-approved advisors, brokers and consultants. Additionally, depending on the report type, we can provide reports online through secure email. The standard claim-related reports we offer to you is dependent upon your plan of benefits, but can include claim, utilization, accounting and banking reports.

### Granting your broker access

At your request, and with the appropriate agreements in place, we can authorize brokers or consultants as designated users of Analyze-Rethink-Transform (ART), our powerful analytic platform. With self-service access for registered users, ART provides key metrics and trends affecting costs, behaviors and plan performance. ART allows users to explore data for new insights in areas like social determinants of health. With an integrated view across medical and pharmacy plan information, users discover powerful insights and understanding of member well-being and plan performance.

For self-funded customers, brokers or consultants may also have access to monthly claim reporting through secure email. We format the file in Microsoft Excel and compress it using WinZip. The file contains recorded claim records for the reporting month. This financial file is an audit trail for the claim activity for the month. At the direction of our customers and with proper privacy agreements in place, we can send our claim reports to whomever they deem appropriate, including brokers.

There's no charge for a consultant or broker to have access to these reports.

## **Exhibit “C” – Cover Page**

1. Insurance Requirements
2. Approved Insurance

## INSURANCE REQUIREMENTS

CONTRACTOR shall not commence services under the terms of this Agreement until certification or proof of insurance detailing terms and provisions has been received and approved in writing by the CITY's Risk Manager. If you are responding to a bid and have questions regarding the insurance requirements hereunder, please contact the City's Purchasing Department at (954) 786-4098. If the contract has already been awarded, please direct any queries and proof of the requisite insurance coverage to City staff responsible for oversight of the subject project/contract.

CONTRACTOR is responsible to deliver to the CITY for timely review and written approval/disapproval Certificates of Insurance which evidence that all insurance required hereunder is in full force and effect and which include on a primary basis, the CITY as an additional insured on Commercial General Liability coverage. **Such policy or policies shall be issued by United States Treasury approved companies authorized to do business in the State of Florida or coverages may be placed with financially sound insurers that are not licensed or admitted in all states, in compliance with applicable surplus lines laws. The policies shall be written on forms acceptable to the City's Risk Manager, meet a minimum financial A.M. Best and Company rating of no less than Excellent, and be part of the Florida Insurance Guarantee Association Act. No changes are to be made to these specifications without prior written approval of the City's Risk Manager.**

Throughout the term of this Agreement, CITY, by and through its Risk Manager, reserve the right to review, modify, reject or accept any insurance policies required by this Agreement, including limits, coverages or endorsements. CITY reserves the right, but not the obligation, to review and reject any insurer providing coverage because of poor financial condition or failure to operate legally.

Failure to maintain the required insurance shall be considered an event of default. The requirements herein, as well as CITY's review or acceptance of insurance maintained by CONTRACTOR, are not intended to and shall not in any way limit or qualify the liabilities and obligations assumed by CONTRACTOR under this Agreement.

Throughout the term of this Agreement, CONTRACTOR shall, at their sole expense, maintain in full force and effect, the following insurance coverages and limits described herein, including endorsements.

A. Worker's Compensation Insurance covering all employees and providing benefits as required by Florida Statute, Chapter 440, regardless of the size of the company (number of employees) or the state in which the work is to be performed or of the state in which Contractor is obligated to pay compensation to employees engaged in the performance of the work. Contractor further agrees to be responsible for employment, control and conduct of its employees and for any injury sustained by such employees in the course of their employment.

B. Liability Insurance.

(1) Including the City of Pompano Beach as an additional insured as City's interests may appear, on General Liability Insurance only, relative to claims which arise from Contractor's negligent acts or omissions in connection with Contractor's performance under this Agreement.

(2) Such Liability insurance shall include the following checked types of insurance and indicated minimum policy limits.

<b>Type of Insurance</b>	<b>Limits of Liability</b>
<b>GENERAL LIABILITY:</b>	Minimum \$1,000,000 Per Occurrence and \$2,000,000 Per Aggregate
* Policy to be written on a claims incurred basis	
XX_ comprehensive form	bodily injury and property damage
XX_ premises - operations	bodily injury and property damage
_ explosion & collapse hazard	
_ underground hazard	
XX_ products/completed operations hazard	bodily injury and property damage combined
XX_ contractual insurance	bodily injury and property damage combined
XX_ broad form property damage independent contractors	bodily injury and property damage combined
_ personal injury	personal injury
XX_ CG2010	ongoing operations (or its' equivalent)
XX_ CG 2037	completed operations (or its' equivalent)
_ sexual abuse/molestation	Minimum \$1,000,000 Per Occurrence and Aggregate

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**AUTOMOBILE LIABILITY:**  Minimum \$1,000,000 Per Occurrence and \$2,000,000 Per Aggregate. Bodily injury (each person) bodily injury (each accident), property damage, bodily injury and property damage combined.

comprehensive form  
 XX owned  
 XX hired  
 XX non-owned  
 Minimum \$10,000/\$20,000/\$10,000 (Florida's Minimum Coverage)

Please note that Florida Statute Section 255.05 requires contractors who enter into a contract with the City to purchase a payment and performance bond when the contract is in excess of \$200,000.

**REAL & PERSONAL PROPERTY**

comprehensive form                      Agent must show proof they have this coverage.

<b>EXCESS LIABILITY</b>		Per Occurrence	Aggregate
XX umbrella (Drop Down).	bodily injury and property damage combined	\$2,000,000	\$2,000,000

<b>ENVIRONMENTAL/POLLUTION LIABILITY</b>		Per Occurrence	Aggregate
* Policy to be written on a claims made basis		\$1,000,000	\$1,000,000

**CONTRACTOR is required to provide Environmental/Pollution Liability for damage(s) caused by hazardous waste material.**

<b>PROFESSIONAL LIABILITY</b>		Per Occurrence	Aggregate
XX * Policy to be written on a claims made basis		\$2,000,000	\$2,000,000

**Broker is required to provide Professional Liability.**

<b>CYBER LIABILITY (Technology)</b>		Per Occurrence	Aggregate
XX * Policy to be written on a claims made basis		\$2,000,000	\$4,000,000
XX_ Network Security / Privacy Liability			
XX_ Breach Response / Notification Sublimit (minimum limit of 50% of policy aggregate)			
XX_ At a minimum the policy must include the following:			

- o Data breach response costs
- o Unauthorized access / use
- o HIPAA/privacy violations
- o Notification costs
- o Credit monitoring
- o Regulatory defense and penalties

XX\_ Technology Products E&O - \$2,000,000 (only applicable for vendors supplying technology related services and or products)

XX\_ Coverage shall be maintained in effect during the period of the Agreement and for not less than four (4) years after termination/ completion of the Agreement.

**CRIME LIABILITY**

	Per Occurrence	Aggregate
— * Policy to be written on a claims made basis	\$1,000,000	\$1,000,000

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(3) If Professional Liability insurance is required, Contractor agrees the indemnification and hold harmless provisions of Section 12 of the Agreement shall survive the termination or expiration of the Agreement for a period of three (3) years unless terminated sooner by the applicable statute of limitations.

C. Employer’s Liability. CONTRACTOR shall, for the benefit of their employees, provide, carry, maintain and pay for Employer's Liability Insurance in the minimum amount of One Hundred Thousand Dollars (\$100,000.00) per employee, Five Hundred Thousand Dollars (\$500,000) per aggregate.

D. Policies: Whenever, under the provisions of this Agreement, insurance is required of the CONTRACTOR, the CONTRACTOR shall promptly provide the following:

- (1) Certificates of Insurance evidencing the required coverage;
- (2) Names and addresses of companies providing coverage;
- (3) Effective and expiration dates of policies; and

(4) CONTRACTOR agrees to provide Thirty (30) days written notice to the City of Pompano Beach as an additional insured if any of the required insurance policies be canceled before the expiration date, or there is any substantial material change or substantial modification of any of the required insurance policies.

E. Insurance Cancellation or Modification. Should any of the required insurance policies be canceled before the expiration date, or modified or substantially modified, the issuing company shall provide thirty (30) days written notice to the CITY.

F. Waiver of Subrogation. CONTRACTOR hereby waives any and all right of subrogation against the CITY, its officers, employees and agents for the applicable required insurance per this Agreement. When required by the insurer, or should a policy condition not permit an insured to enter into a pre-loss agreement to waive subrogation without an endorsement, then CONTRACTOR shall notify the insurer and request the policy be endorsed with a Waiver of Transfer of Rights of Recovery Against Others, or its equivalent. This Waiver of Subrogation requirement shall not apply to any policy which includes a condition to the policy not specifically prohibiting such an endorsement, or voids coverage should CONTRACTOR enter into such an agreement on a pre-loss basis.

**Please note that Florida Statue Section 255.05 requires contractors who enter into a contract with the City to purchase a payment and performance bond when the contract is in excess of \$200,000.**

## **Exhibit “D” – Policy**

### 1. Fully Insured and Filed Policy



An Aetna Proposal  
Presented to

**City of Pompano Beach**

Effective: October 1, 2026

**City of Pompano Beach**  
**Proposed Offering**

**Contact Information**

Account Executive: Renthia Jackson Email: rxjackson@aetna.com  
Telephone Number: 954-375-1577

**Assumptions**

Contract State: FL Lives: 922  
Commissions: 0.00% Sic Code: 9111  
Mem/EE Ratio: 1.77  
Rx Formulary: Advanced Control Formulary Aetna Insured

**Proposed Rates**      **Effective Date:** October 1, 2026      **End Date:** September 30, 2027

Coverage	Lives	Monthly Rate PEPM	Monthly Amount Due
<b>OA EPO (Elect Choice)</b>			
EE	22	\$736.90	\$16,212
Family	56	\$1,974.96	\$110,598
<b>Total</b>	<b>78</b>		<b>\$126,810</b>
<b>OA POS (Managed Choice)</b>			
EE	611	\$1,084.81	\$662,819
Family	187	\$2,490.91	\$465,800
<b>Total</b>	<b>798</b>		<b>\$1,128,619</b>
<b>OA POS (Managed Choice) Retiree</b>			
EE	35	\$813.61	\$28,476
Family	11	\$1,864.67	\$20,511
<b>Total</b>	<b>46</b>		<b>\$48,988</b>
<b>Total Medical Lives</b>	<b>922</b>		
<b>Monthly Total Amount Due</b>			<b>\$1,304,416</b>
<b>Total Contract Period Amount Due</b>			<b>\$15,652,996</b>

**\*Clarifications**

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

The information contained in this proposal is confidential and should not be shared with anyone other than your broker or benefit plan consultant.

## City of Pompano Beach

**Premium Credit**

**Effective Date: October 01, 2026**

**Policy Period: October 1, 2026 through September 30, 2027**  
**Medical Premium Credit: \$310,000**

We are offering a either a one-time premium credit in the amount stated above or an MBR Rate Cap, of which you must choose one. This credit will be applied starting with the second month's bill in the Policy Period unless you notify us otherwise at the time of sale. The credit will be included as part of the final contract and subject to the following provisions:

- a. Our Fully Insured medical policy will remain in effect for the duration of the Policy Period.
- b. You are required to make the premium payments in accordance with contract provisions.
- c. Standard contract termination provisions apply.
- d. All of the plan caveats as stated on the Caveats page in the final proposal are met.
- e. We pay the producer based on the amount you pay in premium. We do not pay the producer for any credits you received to your total premium.
- f. Future renewals will be calculated based on the annualized premium before giving any effect to the premium credit.

In the event that any of these provisions are not met or you terminate the contract prior to the end of the Policy Period listed above, you will be required to pay us the total amount of the credit within 31 days of notice of non-compliance.

The premium rates shown on the accompanying Rate Sheet will be billed every month of the Policy Period. The premium credit will be shown as a separate line item. When you accept our quote, the Rate Sheet will become part of your Group Agreement with us.

You may wish to consult with your legal advisors about any changes that you may need to make in the administration of your plan as a result of this credit consistent with your fiduciary obligations such as making adjustments to participant contributions.

Signature below indicates acceptance of these terms.

\_\_\_\_\_  
Shannon Blakeslee – Underwriting Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
Officer – City of Pompano Beach

\_\_\_\_\_  
Date



## City of Pompano Beach

### Medical Benefit Ratio Rate Cap - Prospective Effective Date: October 01, 2026

**Guarantee Period (Year 2):** October 1, 2027 through September 30, 2028  
**Prior Period (Year 1):** October 1, 2026 through September 30, 2027

We are offering a either a one-time premium credit or an MBR Rate Cap stated below, of which you must choose one. We guarantee your per member, per month (PMPM) premium for the Guarantee Period won't increase by more than the percentage stated in the chart below from the Prior Period premium PMPM based on your Medical Benefit Ratio (MBR).

Each plan is renewed separately then reviewed in aggregate against the maximum overall rate increase.

Year One (2026)			Year Two (2027)
Experience MBR			Rate Cap
87.0% and under	to	88.9%	11.50%
89.0%	to	90.9%	14.50%
91.0%	to	92.9%	17.00%
93.0%	to	94.9%	19.50%
95.0%	to	96.9%	22.00%
97.0%	to	98.9% and above	No Guarantee

The Year One Experience MBR is calculated by:

$$\frac{\text{Blended Projected Claims (PMPM)}}{\text{Total estimated premium collected in Year One policy period (PMPM)}}$$

Blended Projected Claims are medical and pharmacy per member per month incurred and completed claims trended and adjusted to reflect the Year One benefits for all plan options and blended with manual when not fully credible. The claims reflect the pooling charge and removal of pooled claims. We'll use a minimum of 12 consecutive months of claims ending in our latest claims available at the time of renewal delivery. Claims are experience weighted when more than 12 months of experience is available.

Total estimated premium is Year One policy period per member, per month premium excluding broker compensation, taxes, and allowances (if applicable). The Year One policy period per member, per month premium will be based on the estimated total number of participants enrolled in the Medical plans.

In addition, the pooling threshold used in the calculation of Year One Experience MBR will not be any higher than \$250,000, provided that the plans/programs remain the same and the enrollment in total and by plan remains similar to current; we will also apply our standard pooling charges in the calculation.

The maximum premium rate increase will be the percentage listed above plus any applicable change in Federal (ACA or otherwise) or State Tax, Fees, or Assessments for the subsequent 12-month period. Any additional taxes or fees resulting from new Federal or State legislation will be added to the premium before the premium rate increase is applied.



## City of Pompano Beach

Medical Benefit Ratio Rate Cap - Prospective

Effective Date: October 01, 2026

### Conditions for the Guarantee:

We reserve the right to revise or remove the guarantee if any of the following occur during or prior to the guarantee period:

- **Novel Conditions and Circumstances**

This offer does not contemplate the changes in costs, utilization, risk or any form or type of testing associated with novel conditions or circumstances affecting broad populations that place a significant strain on the health care system and/or your plan(s). These conditions include but are not limited to COVID-19. We reserve the right to adjust the terms and factors of this guarantee in response to these conditions and/or circumstances if necessary.

- **Base Year Claims**

We reserve the right to adjust base year/gap claims used in the development of our experience and rate projection to account for the anticipated impact of novel conditions, as stated above. These adjustments would be applied to normalize the experience for the projected impact of these conditions. (Only applies to cases that are partially or fully experience rated at the time of proposal.)

- **Group Size Variation**

- A total of 922 employees are expected to be enrolled in the quoted medical products.
- Of this assumed enrollment, the combined enrolled COBRA, pre-65 retirees, and disabled employees does not vary by more than two percent of the total Aetna covered group from the originally assumed enrollment. In addition, we assume that the combined enrolled COBRA, pre-65 retirees, and disabled employees will not comprise more than five percent of total Aetna covered group.

- **Data Requirement**

Since this guarantee is partially based on the prior carrier(s) claims, Aetna must receive complete mature incurred claims experience from prior carrier(s) 30 days prior to the renewal delivery date. We will need:

- Data will be provided in a summary format, preferably in excel, and will include, by incurred month: medical claims, capitation (if applicable), pharmacy claims, HRA fund claims (if applicable), subscribers and members.
  - Claim summaries should be provided separately for each plan design (basic, buy up, HMO, POS, PPO, etc.) and for each prior carrier.
  - Claims experience must be complete mature claims incurred to October 1, 2027 and paid through January 31, 2028.
  - Claims should represent subscriber groups included in this guarantee.
  - We require information on large claims by plan for claims in excess of \$25,000 per member; medical and pharmacy amounts should be listed separately.
- The premium rate increase is subject to the terms and conditions as stated in the caveats.
  - A change of greater than 10 percent from the assumed enrollment in total or by plan.
  - A change in the quoted plan designs.
  - A change of greater than 10 percent from the current employee contributions.
  - We are no longer the sole provider of medical and pharmacy coverage including any self-funded plans we offer you.
  - Failure to make your required premium payments in accordance with contract provisions.
  - The plan is no longer experience rated. (Only applies to cases that are partially or fully experience rated at the time of proposal.)
  - The medical plan is put out to bid for the first renewal period.
  - Material changes required by legislative or regulatory action or initiated by you to the plan of benefits offered, claim payment requirements or procedures, changes in state premium taxes or assessments, or any other changes affecting the manner or cost of providing coverage.
  - Filing changes that affect our ability to offer this guarantee or exercise underwriting judgment.



## City of Pompano Beach

### MBR Rate Cap Reconciliation Example

Effective Date: October 01, 2026

#### For Illustrative Purposes Only

Each plan is renewed separately then reviewed in aggregate against the maximum overall rate increase.

Year One (2026) Experience MBR			Year Two (2027) Rate Cap
80.0%	to	81.9%	6.0%
82.0%	to	83.9%	8.5%
84.0%	to	85.9%	11.0%
86.0%	to	87.9%	14.0%
88.0%	to	89.9%	16.5%
90.0%	to	91.9%	19.0%
92.0%	to	93.9% and above	No Guarantee

The Year One Experience MBR is calculated by:

$$\frac{\text{Blended Projected Claims (PMPM)}}{\text{Total estimated premium collected in Year One policy period (PMPM)}}$$

Refer to the guarantee document for definitions.

#### Example (For Illustrative Purposes Only)

##### Year One Blended Projected Claims

Experience Period: 2/1/2027 through 1/31/2028

1. Blended Projected Claims PMPM (Year Two)	\$380.00
2. Trend	
a. Blended Annual Trend	11.24%
b. Minus Year 2 Trend Months	(12.0)
c. Trend Adjustment Factor	0.8990
3. Blended Projected Claims PMPM (Year One) (1 x 2c)	\$341.60

##### Year One Total Premium

4. Total Estimated Current Premium PMPM	\$425.00
5. Producer Service Fee	5.00%
	(\$21.25)
6. Premium Tax/Health Insurance Assessment	(\$3.24)
7. Allowance(s) PMPM	(\$2.50)
8. Final Premium PMPM	\$398.01

**Actual Experience MBR (3 / 7)** **85.8%**

**Year Two Rate Cap** **11.0%**



## City of Pompano Beach

Programs and Services - Conventional Prospective		Effective Date: October 01, 2026		
Program Summary	OA EPO	OA MC	OA MC Retiree	
<b>Implementation/Account Management</b>				
Designated Account Management Team	Yes	Yes	Yes	
Designated Service Center	Yes	Yes	Yes	
Open Enrollment Marketing Material	Yes	Yes	Yes	
ID Cards	Yes	Yes	Yes	
<b>Network Services</b>				
CVS Health Virtual Care™	Yes	Yes	Yes	
Gene-Based, Cellular and other Innovative Therapies (GCIT®) network	Yes	Yes	Yes	
Institutes of Excellence™	Yes	Yes	Yes	
National Advantage™ Program	Yes	Yes	Yes	
National Medical Excellence Program®	Yes	Yes	Yes	
<b>Care Management</b>				
Aetna Healthy Chapters™	Yes	Yes	Yes	
Aetna One® Flex	Yes	Yes	Yes	
Enhanced Clinical Review	Yes	Yes	Yes	
MedQuery® with physician messaging	Yes	Yes	Yes	
Utilization Management	Yes	Yes	Yes	
<b>Member Resources</b>				
Member Services	Yes	Yes	Yes	
Aetna Concierge	Yes	Yes	Yes	
Member Website and Mobile Experience	Yes	Yes	Yes	
<b>Wellness Programs and Services</b>				
Aetna Health Your Way™ Core	Yes	Yes	Yes	
Dedicated Health Coach/Wellness Consultant (Full FTE)	Yes	Yes	Yes	
24-Hour Nurse Line (frm.IHL): 1-800# Only	Yes	Yes	Yes	
<b>Reporting</b>				
Utilization Management Reporting	Yes	Yes	Yes	
<b>Behavioral Health</b>				
Applied Behavioral Analysis (ABA)	Yes	Yes	Yes	
Managed Behavioral Health	Yes	Yes	Yes	
<b>Allowances</b>				
Wellness Allowance	Yes	Yes	Yes	
Technology Allowance	Yes	Yes	Yes	

Your benefit plans may include access to CVS Health Virtual Primary Care™ and/or Teladoc Health for telemedicine services where available.

## City of Pompano Beach

### Programs and Services - Conventional Prospective

Effective Date: October 01, 2026

#### Allowances

We are including the following allowance(s) for your Aetna plans for the October 1, 2026 through September 30, 2027 plan year. Allowance dollars must be used for your commercial Aetna medical plan(s) and Aetna medical members.

- Wellness: \$100,000
- Technology: \$50,000

Annual allowance amounts may be adjusted if actual enrollment changes by 10 percent or more from our enrollment assumptions.

#### Wellness and Technology Allowances

- The **Wellness** allowance can be used to offset reasonable documented wellness-related programs or activities expenses incurred during the plan year. Wellness allowance expenses must be for wellness-related programs or activities that are reasonably designed to promote the health and well-being of Aetna members, or to educate Aetna members about healthy lifestyles and/or prevent disease. This means that there must be a connection to the health and well-being of the members, with a focus on preventative measures or healthy living (i.e., diet, exercise), not on acute care. Wellness programs and activities funded by allowance funds are not covered benefits under your Aetna plan.
- The **Technology** allowance can be used to offset reasonable documented technology-related expenses for services you received from third-party vendors incurred during the plan year. Your allowance must be used for system enhancements to facilitate your Aetna medical plan benefit administration or Aetna member eligibility.
- All allowance submissions, including those submitted by a third-party vendor, must comply with these conditions.

The above referenced fund(s) will be available as of the effective date of the plan year. Only those expenses performed and billed by a third party are payable. Reimbursement for time and materials incurred directly by the plan sponsor (e.g., hours worked by the plan sponsor's own employees) are not eligible. Your normal business operation expenses, including employee salaries and overtime, are not eligible under the allowance. Our preferred method of payment is directly to the third-party vendor. We require submission of appropriate documentation detailing charges for the services provided by the vendor. Acceptable documentation includes, but is not limited to, detailed vendor invoices itemizing services provided, specific cost-elements and associated line-item charges.

On an exception basis, we can reimburse you directly provided you submit both the detailed invoice and receipt showing payment to the third-party vendor.

You should submit documentations within 60 days of the invoice date. We must receive all documentation no later than 60 days following the close of the plan year to be considered for reimbursement.

The allowance(s) indicated above are forfeited at the end of the plan year if not fully utilized. There is no roll over of unused funds to the next policy year. Any unredeemed wellness incentives that may be offered through a "reward program" are forfeited at the end of each plan year.

We assume the funding of any allowance is either at the request of your Plan Administrator acting in its fiduciary capacity or for the exclusive benefit of your Plan. You are responsible for determining that your use of allowance dollars is appropriate and legally compliant. With respect to allowance dollars that are used in connection with a wellness program, you are responsible for ensuring that the program and any incentives/rewards comply with applicable laws, including limitations on maximum allowable wellness incentives/rewards. We will pay any allowances in accordance with applicable law. We suggest you seek appropriate accounting and legal counsel for all payments to ensure they comply with applicable accounting principles and law.

If you terminate your medical plan with us in whole or in part (defined as a 50 percent or greater membership reduction from the membership we assumed in this proposal) prior to the end of the plan year, you'll be responsible for remitting payment for any allowance amounts used. Payment is due to us within 31 days of the invoice.

## City of Pompano Beach

### Caveats - Conventional Prospective

Effective Date: October 01, 2026

For the purposes of this document, Aetna may be referred to using "we," "our" or "us" and City of Pompano Beach may be referred to using "you" or "your".

Our quoted rates are proposed for the policy period effective October 01, 2026 through September 30, 2027.

Our proposal is illustrative and subject to change based upon underwriting review of the information listed and requested below. Any of the information listed below, which has not been provided, may be required prior to final approval of sale. You'll receive firm rates approximately 150 days prior to the effective date.

The caveats below apply to any future rate adjustments made for the same policy period unless new caveats and assumptions are provided.

### Documentation

#### Current

Current rates/fees and plan designs.

#### Renewal

Current carrier's renewal offer including rates/fees and plan design.

#### Billing Statement

Complete copy of the most recent billing statement, within one month of the effective date.

#### Claims Information

Updated monthly claims and large claim information on incumbent carrier letterhead on a rolling 12-month basis with corresponding exposures up to 150 days prior to the effective date. Large claim information must include diagnoses for all claimants in excess of \$25,000.

If monthly claims and/or large claim information were not provided with this proposal request or you are unable to provide monthly claims and large claim information, we'll require completed Medical Questionnaire(s) signed by your officer, representative, and/or employee(s).

#### Demographics

Complete census data with all eligible members in Excel from you, including: each member's date of birth, insurance status, dependent coverage, gender, and home zip code. Census should also identify whether each member is included on a contract which is active, COBRA, part-time, union, early retiree, retiree or waiver and the plan/product in which the member is part-time workers are eligible.

## City of Pompano Beach

**Caveats - Conventional Prospective**

**Effective Date: October 01, 2026**

### Underwriting Caveats

We reserve the right to revise the premium, modify the terms of the offer or terminate if:

#### **Enrollment**

There is a 10 percent change in the enrolled number of employees in total or by plan from our enrollment assumptions. This includes the impact of new or terminating locations and/or groups. (Change in census is based on additions and subtractions - a 60 life group who adds 3 people and takes away 3 others has a 6 person change in census even though they stay at 60 lives.) Our proposal assumes coverage will not be extended to additional employee groups without review of supplemental census information and other underwriting information for appropriate financial review.

#### **Member-to-Employee Ratio**

The member-to-employee ratio changes by more than 10 percent from the 1.77 ratio assumed in this quote.

#### **COBRA Enrollment**

The number of COBRA enrollees exceeds 10 percent of the total enrolled group or changes by more than 2 percent from the 92 enrollees assumed in this quote. COBRA enrollees must be eligible for the same benefits as the active population.

#### **Retiree Enrollment**

The number of early or non-Medicare eligible retirees exceeds 10 percent of the total enrolled group or changes by more than 2 percent from the 74 enrollees assumed in this quote. Early or non-Medicare eligible retirees must be eligible for the same benefits as the active population. Patient Management programs are excluded for Medicare primary members.

#### **Group Size**

In the event a Large Group, during the previous year, becomes a Small Group under the definition of Small Group of the situs state, the Large Group policy may not be renewed.

#### **Plan Eligibility**

The quoted plans are only for active employees and pre-65 retirees.

#### **Large Claims**

The enclosed rate assume that there are no known additional ongoing catastrophic/large claimants other than those already identified to us in this request for proposal process.

#### **Quoted Benefits and Administration**

A material change is initiated by you or by legislative or regulatory action which affects the cost of the plan. A material change includes, but is not limited to, changes impacting standard contract provisions, account structure, claim settlement practices, plan administration, plan benefits or changes to the programs and services we offer you.

#### **Industry**

The nature of business and/or SIC code changes from the 9111 code assumed in this quote.

#### **Total Replacement**

Any of the quoted lines of coverage are offered with an additional carrier.

#### **Affordable Care Act Non-Renewal**

Under Affordable Care Act (ACA) and state insurance regulations, a group health insurance policy may be non-renewed for certain reasons.

#### **Multiple Employer Welfare Arrangements (MEWAs) and Employer Association Health Plans (AHPs)**

This quote was prepared based on the situs state and demographic information for eligible enrollees, including their home zip codes, in accordance with all federal and state mandates. We must be notified immediately of any changes that affect plan locations due to new or changing enrollment status. We will evaluate regulatory requirements and may not be able to extend coverage in states which prohibit large group coverage through MEWAs and AHPs.

## City of Pompano Beach

**Caveats - Conventional Prospective**

**Effective Date: October 01, 2026**

### Assumptions

#### Underwriting

#### **Prospective Quoting**

The quoted insured medical rates are offered on a prospectively rated basis. No policy year accounting balance will be calculated for these coverages.

#### **Participation**

Our rates assume at least 75 percent of eligible employees excluding spousal and parental waivers must enroll in our Medical plans, but not less than 50 percent of all eligible employees regardless of spousal and parental waivers. We may adjust your final rates if our final participation level changes by more than 10 percent from what was assumed or falls below 30 percent of eligible employees regardless of spousal or parental waivers. Where federal law and state law permit, we may non-renew if our participation level falls below 20 percent of eligible employees participants regardless of spousal or parental waivers.

#### **Contributions**

You must provide the contribution strategy for both current and proposed plan(s).

#### **Plan Design**

This proposal is based on the current benefit plan designs, plus any noted deviations. Our standard provisions, contract wording and claim settlement practices will apply for items not specifically outlined. All applicable government regulations and state mandates will apply. These products are offered subject to the terms of our Benefit Review Document.

#### **Underlying Plan**

Our rates assume that there are no underlying plans in effect that will either partially or completely subsidize any member cost sharing including but not limited to copays, deductibles, and/or coinsurance balances.

#### **Prescription Drug Benefits**

Prescription drug benefits are included and will be provided by Aetna.

#### **Point of Service Rebates**

This proposal may include point of service rebates ("POS Rebates") favorable to, and shared with, eligible subscribers and dependents. However, Aetna reserves the right to make appropriate changes to the premium offered hereunder in the event POS Rebates are discontinued, in whole or in part, on account of any material changes made to

- (i) the laws, rules and/or regulations applicable to POS Rebates or
- (ii) any material drug manufacturer rebate contracts providing the source for POS Rebates.

#### **Additional Products, Programs and Services**

Costs for special services rendered that are not included or assumed in the pricing guarantee will be direct-billed after such services have been rendered. For example, you will be subject to additional charges for customized communication materials, as well as costs associated with custom reporting, booklet and SPD printing, etc. The costs for these types of services will depend upon the actual services performed and will be determined at the time the service is requested.

#### **Member Communications**

Pricing assumptions include direct communications access to Aetna membership through both ongoing Aetna Health communications and relevant ongoing included product/program specific communications. These communications can reduce member and plan costs by guiding in care navigation, managing chronic conditions, promoting preventive services, and more.

### Billing Information

#### **Billing and Payment of Premium**

Amount due is payable on the first day of the month covered by the invoice. If the amount due is not paid in full within 30 days, we reserve the right to terminate the contract and/or assess late premium payment charges.

#### **Producer Compensation**

We are not serving as billing and collection agent for producer compensation. Our quoted rates do not include Producer Service Fees or commissions.



## City of Pompano Beach

**Caveats - Conventional Prospective**

**Effective Date: October 01, 2026**

### Claim and Member Services

#### Run-In Claim Processing

Our proposal excludes run-in claim processing from the prior carrier (claims incurred before the effective date of the plan).

#### Summary Plan Description (SPD) Modification

We've assumed that the standard SPD language will be used and any customization may require an additional cost.

### Reporting and Data Transfer

#### Aetna Intellectual Property

Under the Group Policy, you may have access to certain of Aetna's Customer reporting systems. Aetna represents that it has either the ownership rights or the right to use all of the intellectual property used by Aetna in providing the Services under the Group Policy ("Aetna IP"). Aetna will grant you, as the Customer, a nonexclusive, non-assignable, royalty free, limited right to use certain of the Aetna IP for the purposes described in the Group Policy. You agree not to modify, create derivative product from, copy, duplicate, decompile, disassemble, reverse engineer or otherwise attempt to perceive the source code from which any software component of the Aetna IP is compiled or interpreted. Nothing in the Group Policy shall be deemed to grant any additional ownership rights in, or any right to assign, sublicense, sell, resell, lease, rent, or otherwise transfer or convey, the Aetna IP to you.

### Additional

Please review the additional important information found at the following URL. This information is incorporated by reference into this package and considered part of your policy. This quote is subject to all the terms and conditions set forth in this URL. In the event that any information contained herein conflicts or is inconsistent with the information in the Underwriting Disclosure document, the information in your package prevails.

<https://www.aetna.com/content/dam/aetna/pdfs/aetnaom/legal-notice/documents/large-group-insured-medical-underwriting-disclosures-as-of-01-01-2026.pdf>

### Legislative and Regulatory Requirements

#### Affordable Care Act (ACA) Taxes and Fees

The Affordable Care Act (ACA) imposes several fees/assessments. The Health Insurance Provider Fee (HIF) was applicable in 2020, but a federal omnibus bill signed on December 20, 2019 repealed the HIF for 2021 and beyond. Still applicable in 2026 is Patient-Centered Outcomes Research Trust Fund fee (PCORI). It applies to issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans. The fee was set to end in 2019, but it was extended for 10 years through 2029. The fee applies to policy or plan years ending on or after October 1, 2012, and before October 1, 2029.

This rate quote includes, as applicable, an estimate of the PCORI fee. We reserve the right to modify the rate, or otherwise recoup such fees, based on future regulatory guidance, subsequent state regulatory approvals, or if estimates are materially insufficient.

#### Regulatory Reporting

We are entitled to rely on information supplied by you in connection with any regulatory filings we provide on your behalf or any other services we provide. We are not responsible for any penalties or fees associated with reporting delays/errors caused by your failure to provide us with accurate or timely information.

#### Mandates

Benefit provisions are subject to state, local, and federal mandates. Future mandates will be incorporated in the plan(s) as of the date required by law and may require rate adjustments.