Pharmacy P.O. Box 839999, San Antonio, Texas 78283-3999

**HEB Pharmacy Agreement to Administer Immunizations for**

**I. Overview**

HEB Pharmacy (HEB) will provide flu immunizations to (EMPLOYER) employees on agreed-upon clinic dates. HEB will supply licensed and certified personnel to perform flu immunizations and will supply all vaccine, medical supplies, and forms. Benefit eligibility will be verified at the time of service through an employee identification process agreed to by EMPLOYER. HEB will offer flu shots to non-eligible employees and guests through individual payment at the discounted price offered to EMPLOYER.

**II. Pricing****

HEB will offer two types of flu vaccine for EMPLOYER flu clinic(s). Your HEB Pharmacy contact can explain the difference in product to you. Once the vaccine is selected, HEB will provide the above services to EMPLOYER employees either through insurance billing or invoicing arrangement as outlined below. Vaccinations billed to EMPLOYER insurance will be billed via claims submission at the prevailing insurance contract rate between EMPLOYER insurance and HEB. For vaccinations invoiced to EMPLOYER, HEB will extend the following rates:

- Trivalent Vaccine - $12 per dose
- Quadrivalent Vaccine – price per grid below
- High dose - $75.00 per dose

| # of shots | Price per dose of Quadrivalent Vaccine | Maximum immunizer time at site |
|---|---|---|
| 40-100 | $36.00 | 1 hour |
| 101-200 | $35.00 | 3 hours |
| 201+ | $34.00 | Varies |

** The discounted rates shown are contingent on EMPLOYER granting exclusive rights to HEB to execute flu vaccination clinics at the sites designated below for the period from August 1, 2015 through January 31, 2016, and availability of vaccine. HEB may change the pricing set forth herein at any time to reflect changes in supply and/or procurement costs and/or other changes in the market upon 30 days' prior written notice to you.

**III. Product selection**

EMPLOYER has selected ☒ Quadrivalent vaccine ☒ Trivalent vaccine (check all that apply), with the following conditions (if any):

_____

_____

**IV. Clinic Scheduling**

| Site | Date | Est. # of Shots |
|---|---|---|
| On Williamson County Locations | Schedule as attached | 250+ |
| | | |
| | | |
| | | |

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V. **Billing** - For each question below, please check your response and fill in the corresponding blanks

1. **Services paid on-site at time of service?**

☐ Yes

Employer Pay $_____

*Participant Copay $_____

☒ No

Proceed to # 2

2. **H-E-B bill insurance electronically (claims submission)?**

☒ Yes

Insurance Name: aetna

BIN and PCN: _____

Group #: _____

Insurance Pay: _____

*Participant Copay: _____

☐ No Proceed to #3

3. **H-E-B bill <u>INSURANCE</u> via invoice after clinic completion?**

☐ Yes

Insurance Name: _____

Insurance Pay $_____

*Participant Copay $_____

Where to mail invoice? _____

_____

_____

Billing requirement: (i.e. Do you need employee names, employee signature, etc)

Yes, Employee Name, Signature & Medical ID# or EMP #

_____

☐ No Proceed to #4

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**4. H-E-B Bill EMPLOYER via invoice after clinic completion?**

☒ Yes

Employer Pay $full

*Participant Copay $0.00

Where to mail invoice?

Billing requirement: (i.e. Do you need employee names, employee signature, etc)

☐ No Proceed to #5

**5. Billing requirements/notes not mentioned in items 1-5?**

*All Participant Co-pays must be paid at the time of service

**VI. Acknowledgement.** I, the undersigned am authorized to make billing and payment arrangements on behalf of _____ for the provision of flu immunizations by H-E-B Pharmacy. I understand and agree that participant flu shots will be invoiced by H-E-B in the manner described above. I understand if payment is not received within 60 days of service, H-E-B will bill the participant directly.

For _____ **Print Name** Dan A Gattis

**Sign**

**Date** 09-30-2015

For HEB **Print Name** Patrick Johnson

**Sign** Patrick Johnson

**Date** 09-21-2015