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October 12, 2022

Guy Hine
Risk Manager
City of Fort Lauderdale
100 North Andrews Avenue
Fort Lauderdale, FL 33301

RE: Administrative Services Only Account No. 3335139

Dear Guy Hine:

This letter will serve as an amendment to the Administrative Services Only Agreement between Cigna Health and Life Insurance Company ("**CHLIC**") and City of Fort Lauderdale ("**Employer**"), effective January 1, 2017, (the "**Agreement**") and as amended on January 1, 2021 and January 1, 2022.

Effective as of January 1, 2023, the Agreement is hereby amended as set forth below. Any provision or subsection set forth in this amendment shall be deemed to: (a) replace in its entirety the same subsection in the current Agreement; and/or (b) add new provisions or subsections. Only those provisions and subsections set forth in this amendment are deemed amended or added, and all provisions and subsections not identified herein shall be deemed unaffected by this amendment and, accordingly, shall remain in full force and effect.

"Agreement" in "Definitions," of the Administrative Services Only Agreement is hereby amended in its entirety as follows:

Agreement means this entire document including the Schedule of Financial Charges and all Exhibits and Addenda, as attached hereto, as well as any subsequent amendments.

Section 8.a of the Administrative Services Only Agreement is hereby amended in its entirety as follows:

a. The Medical Administration Charges in effect from January 1, 2023 through and including December 31, 2025, shall be as set forth in the Schedule of Financial Charges attached hereto and CHLIC may revise such Medical Administration Charges only (i) upon any modification or amendment of the benefits under the Plan, (ii) upon any variation of fifteen percent (15%) or more in the number of Members used by CHLIC to calculate its charges under the Agreement, and/or (iii) upon any change in law or regulation that materially impacts CHLIC liabilities and/or responsibilities under this Agreement.

Section 14, "Waivers," of the Administrative Services Only Agreement is hereby replaced in its entirety with Section 14, "No Waivers," as follows:

Section 14. No Waivers

No waiver by any party of a breach or default of any provision of this Agreement, failure by any party, on one or more occasions, to enforce any of the provisions of this Agreement, or failure by any party to exercise any right or privilege hereunder shall be construed as a waiver of any subsequent breach or default of a similar nature, or as a waiver of such rights or privileges hereunder, unless and solely to the extent waived by the party against whom the waiver is sought in writing and signed.

Section 20, "Identifying Information and Internet Usage," of the Administrative Services Only Agreement is hereby replaced in its entirety with Section 20, "Identifying Information, Internet Usage, and Trademark," as follows:

Section 20. Identifying Information, Internet Usage and Trademark

Each Party reserves all right, title, and interest in and to its respective trademarks, service marks, trade names, trade dress, logos, and other proprietary trade designations, whether presently existing or hereafter authored, developed, established, or acquired (collectively, "Marks"). Except as necessary in the performance of their duties under this Agreement and as otherwise provided by the Florida public records law, or as separately agreed to in writing, no Party shall use the other Party's Marks in advertising or promotional materials or otherwise. All use of a Party's Marks shall remain subject to such Party's reasonable quality control and brand usage guidelines. Additionally, no Party shall establish a link to the other's World Wide Web site, without the owner's prior written consent. All goodwill arising from use of a Party's Marks shall inure exclusively to such Party's benefit.

The obligations set forth in this Section 20 shall survive termination of this Agreement.

Section 21, "Independent Contractors," is hereby added to the Administrative Services Only Agreement as follows:

Section 21. Independent Contractors

The Parties' relationship with respect to each other is that of independent contractors and nothing in this Agreement is intended, and nothing shall be construed to, create an employer/employee, partnership, principal-agent, or joint venture relationship, or to exercise control or direction over the manner or method by which CHLIC performs services hereunder. No Party shall make any statement or take any action that might cause a third party to believe such Party has the authority to transact any business, enter into any agreement, or in any way bind or make any commitment on behalf of the other Party, unless set forth in this Agreement or expressly authorized in writing by a duly authorized officer of the other Party. For the avoidance of doubt, CHLIC is authorized to perform certain services on behalf of Employer under this Agreement and this provision is not intended to in any way diminish that authorization.

Section 22, "Reservation of Intellectual Property Rights," is hereby added to the Administrative Services Only Agreement as follows:

Section 22. Reservation of Intellectual Property Rights

Each Party reserves all right, title, and interest in and to its respective copyrights, patents, trade secrets, trademarks, and other intellectual property, whether presently existing or hereafter authored, invented, developed, or acquired. Without limiting the foregoing, as between the Parties, CHLIC shall solely and exclusively own the systems, methodologies, and technology used to provide the services, all modifications, enhancements, and improvements thereto, and all associated intellectual property rights. No rights or licenses are granted to Employer other than the limited right to receive and use the services under and in accordance with this Agreement. CHLIC shall be free to use and incorporate without payment or other consideration to Employer any ideas, suggestions, recommendations, or other feedback provided to CHLIC in connection with its provision of the services. Nothing in this Agreement is intended or shall be construed to create any joint authorship, joint inventorship, or similar relationship or endeavor between the Parties.

The obligations set forth in this Section 22 shall survive termination of this Agreement.

Section 23, "Entire Agreement," is hereby added to the Administrative Services Only Agreement as follows:

Section 23. Entire Agreement

As of the Effective Date, this Agreement constitutes the entire agreement between the Parties regarding the subject matter herein and supersedes all previous and contemporaneous agreements, understandings, inducements or conditions expressed or implied, oral or written, between the Parties, except as herein contained. Further, this Agreement shall not be modified by any shrink-wrap, click-wrap, browse-wrap, click-through, web-site based, online or use agreements ("Click-Wrap") that purport to be accepted or deemed accepted by download or online acknowledgment and to the extent of any conflict between this Agreement and the Click-Wrap, this Agreement shall control. Each Party acknowledges that in entering into this Agreement, it is not relying on any statement, representation, or warranty, other than those expressly set forth herein. Except as otherwise provided herein the provisions of this Agreement shall control in the event of a conflict with the terms of any other agreement regarding the subject matter herein.

Section 24, "Public Records," is hereby added to the Administrative Services Only Agreement as follows:

Section 24. Public Records

IF CHLIC HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO CHLIC'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS AGREEMENT, CONTACT THE CUSTODIAN OF PUBLIC RECORDS AT CITY CLERK'S OFFICE, 100 NORTH ANDREWS AVENUE, FORT LAUDERDALE, FLORIDA 33301, PHONE: 954-828-5002, EMAIL: PRRCONTRACT@FORTLAUDERDALE.GOV .

Notwithstanding any provision contained in the Agreement, CHLIC shall comply with public records laws, and CHLIC shall:

a. Keep and maintain public records required by the Employer to perform the service.

b. Upon request from the Employer's custodian of public records, provide the Employer 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 Chapter 119, Florida Statutes (2022), as may be amended or revised, 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 contract term and following completion of the contract if CHLIC does not transfer the records to the Employer.

d. Upon completion of the Agreement, transfer, at no cost, to the Employer all public records in possession of CHLIC or keep and maintain public records required by the Employer to perform the service. If CHLIC transfers all public records to the Employer upon completion of the Agreement,

CHLIC shall destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. If CHLIC keeps and maintains public records upon completion of the Agreement, CHLIC shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to the Employer, upon request from the Employer's custodian of public records, in a format that is compatible with the information technology systems of the Employer.

The obligations set forth in this Section 24 shall survive termination of this Agreement.

The "Schedule of Financial Charges" and "Exhibit B", "Services" are hereby deleted in their entirety and replaced with the "Schedule of Financial Charges" and "Exhibit B, "Services," as attached hereto.

Exhibit E, "Conditional Claim/Subrogation Recovery Services," of the Administrative Services Only Agreement is hereby replaced in its entirety.

The terms of the Administrative Services Only Agreement identified above, as mentioned herein, will be effective as of January 1, 2023.

Schedule of Financial Charges

Certain fees and charges identified in this Schedule of Financial Charges will be billed to Employer monthly in accordance with CHLIC's then standard billing practices. However, CHLIC is authorized to pay all fees and charges from the Bank Account unless otherwise specified in this Agreement.

	MEDICAL ADMINISTRATION CHARGES	
Product	**Description**	**Charge**
Medical	Open Access Plus In-Network (OAPIN) with Care Management Preferred (All Plans)	**$37.57/employee/month**
Medical	Open Access Plus (OAP) with Care Management Preferred	**$37.57/employee/month**
Medical	HRA Open Access Plus (OAP) with Care Management Preferred (All Plans)	**$34.22/employee/month**
	MEDICAL NETWORK ACCESS FEE, UTILIZATION MANAGEMENT FEE AND OPTIONAL PROGRAM FEE	
Product	**Description**	**Charge**
Medical	OAPIN Access Fee (All Plans)	**$25.50/employee/month Included in Medical Administration Charge**
Medical	OAP Access Fee	**$25.50/employee/month Included in Medical Administration Charge**
Medical	HRA OAP Access Fee (All Plans)	**$22.15/employee/month Included in Medical Administration Charge**

MULTI-YEAR CHARGE/FEE GUARANTEES		
	The maximum increase for the Medical Administration Charge(s) and Network Access Fee(s) for the 2024 Plan Year will be 0.00% over the 2023 Plan Year charges/fees. The maximum increase for the Medical Administration Charge(s) and Network Access Fee(s) for the 2025 Plan Year will be 0.00% over the 2024 Plan Year charges/fees. The maximum increase for the Medical Administration Charge(s) and Network Access Fee(s) for the 2026 Plan Year will be 2.00% over the 2025 Plan Year charges/fees. The maximum increase for the Medical Administration Charge(s) and Network Access Fee(s) for the 2027 Plan Year will be 2.00% over the 2026 Plan Year charges/fees. The maximum increase for the Medical Administration Charge(s) and Network Access Fee(s) for the 2028 Plan Year will be 2.00% over the 2027 Plan Year charges/fees. The above fee guarantees are not applicable to Pharmacy Administration Fee. The above charges/fees are guaranteed for the time periods identified above, provided, however, that CHLIC may revise the above charges/fees pursuant to Section 8 of this Agreement.	
	CIGNA CHOICE FUND AND OTHER CONSUMER DIRECTED ACCOUNT ADMINISTRATION SERVICES AND CHARGES	
	Product	**Charge**
	Cigna Choice Fund Health Reimbursement Account (HRA) Administration	**For HRA OAP Products: $4.50/employee/month**
Health Advisor – A	The Health Advisor program focuses on engaging targeted Members related to a variety of wellness and prevention topics, and is designed to facilitate healthy behaviors and promote achievement of health-related goals. The program includes the following components: • Health and wellness coaching on high blood pressure, high cholesterol, healthy eating, physical activity and pre-diabetes using multiple coaching sessions, behavior modification techniques and other motivational interviewing and coaching styles to	**For HRA OAP Only: Included in Medical Access Fee**

	encourage behavior change that helps Participants reach established goals. • Education and referral coaching on program topics with referral to appropriate internal and external resources available. • Access to educational materials and web based Member tools and resources. • Identification of gaps in care and outreach to Member to provide coaching for those identified with gaps for high cholesterol, high blood pressure, and additional coaching on other gaps in care will also occur. • Support of Participants identified through predictive modeling with certain preference sensitive care conditions by supplying impartial evidence based medical information, to empower Participants to understand the potential benefits/ disadvantages of a specific course of action and make more informed care decisions. • Answering health and medical related questions. • Counseling Participants on prevention and the benefits of compliance with prescribed medications and treatments.	

AMOUNTS OWED TO CHLIC

CHLIC may pay amounts with its own funds on behalf of Employer or the Plan for charges which Employer or the Plan is obligated to pay under the Agreement including Plan Benefits, Bank Account Payments (including fixed per person payments and pay-for-performance payments to Participating Providers), governmental taxes or assessments and those amounts paid by CHLIC shall be the Employer's financial responsibility. CHLIC is authorized to recover all such amounts from the Bank Account.

FEES FOR PROCESSING RUN-OUT CLAIMS		
OAPIN, OAP and HRA OAP	Run-Out Period of twelve (12) months	**No Additional Cost**

CHLIC MEDICAL COST CONTAINMENT FEES

CHLIC administers the programs listed below to contain costs with respect to charges for health care service/supplies that are covered by the Plan (the "Cost Containment Programs"). In administering these Cost Containment Programs, CHLIC may contract with vendors to perform various tasks related to the Cost Containment Programs. These Cost Containment Programs include services that are performed on claims that are subject to the federal No Surprises Act and are not otherwise subject to state law ("NSA Services").

CHLIC's charge for administering a Cost Containment Program is the applicable percentage indicated in the table below of the:

1) "gross savings" (i.e., the difference between the charge the provider made and the allowable amount resulting from the Cost-Containment Program);

2) "net savings" (i.e., the gross savings less the applicable vendor charge); or

3) "gross recovery" (i.e., the amount recovered as a result of the Cost-Containment Program).

CHLIC will make a per claim charge to the Bank Account that includes both CHLIC's applicable Cost Containment Program charge, as shown in the Sections A through C of the table below, and the applicable vendor charge. CHLIC will pay the vendor its charge.

For charges for covered services received from a non-Participating Provider (including NSA Services and emergency/urgent care services that are covered at the in-network benefit level), CHLIC may apply discounts available under agreements with third parties or through negotiation of the non-Participating Provider's charges whether on a claim-by-claim basis or in advance of services being rendered ("Discounts"). The programs for obtaining the Discounts are identified in Section A and Section B of the table below.

CHLIC's per claim charge for administering the programs listed in Section A and Section B of the table below plus any per claim vendor charges associated with those programs shall not exceed $30,000.00 per claim. Vendor charges for the programs listed in Section A and Section B of the table generally range from 5-11% of gross savings. Specific rates charged by vendors for the programs in Section A and Section B of the table are available upon request, subject to execution of a mutually agreed upon non-disclosure agreement to protect the proprietary vendor information from unauthorized use/disclosure. The administration of charges for covered services from non-Participating Providers described above and in Section A and Section B of the table below is consistent with the claim administration practices with respect to CHLIC's own health care insurance business, unless state law requires otherwise.

A. Cost Containment for Services/Supplies that are not NSA Services

For services/supplies that are not NSA Services, applying the Discounts may result in higher payments than if the maximum reimbursable charge is applied. Whereas application of the maximum reimbursable charge may result in the patient being balance billed for the entire unreimbursed amount, applying the Discounts may avoid balance billing and substantially reduce the patient's out-of-pocket cost.

If no Discount is available or negotiated, reimbursement will be based upon:

(i) If charges are not subject to CHLIC's benefit enhancement policy – the plan's maximum reimbursable charge (in which case the patient may be balance billed by the non-Participating Provider if the provider's charge exceeds the plan's maximum reimbursable charge); or

(ii) If charges are subject to CHLIC's benefit enhancement policy – depending upon the Employer's election:

a. the amount of the non-Participating Provider's billed charge not exceeding the greater of a CHLIC determined percentage of the Medicare allowable amount (the 80th percentile of the reasonable and customary charge if there is no Medicare allowable charge) or the amount required by state or federal law (in some instances, the patient may be balance billed by the non-Participating Provider if the provider's charge exceeds such amount), or

b. the provider's billed charge.

Non-Participating Provider Cost Containment Programs for Services/Supplies that are not NSA Services		
1.	Network Savings Program	**29% of net savings**
2.	Supplemental Network	**29% of net savings**
3.	Medical Bill Review – (Pre-payment Cost Containment for Non-contracted claims):	
	Inpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**Lesser of 5% of hospital bill or the gross savings achieved**
	Outpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
	Physician/Professional Bill Review	
	• Professional Fee Negotiation	**29% of net savings**

<table>
<tr><td></td><td>• Line Item Analysis Re-pricing</td><td>29% of net savings</td></tr>
<tr><td>4.</td><td>For employers that are subject to state laws providing protections from surprise bills: Payment based on amounts other than Network Savings Program, Supplemental Network, and Medical Bill Review. These payments include amounts determined through negotiation or independent dispute resolution under state law. (The charges indicated in the column to the right include the fees charged by government departments or agencies for administering the independent dispute resolution process and the fees charged by entities conducting independent dispute resolution.)</td><td>29% of net savings</td></tr>
<tr><td colspan="3">B. Cost Containment for NSA Services

For NSA Services, CHLIC will issue initial payments at amounts determined by CHLIC or its vendors (“Initial Allowed Amount”). The Initial Allowed Amount may be based on Discounts and may be higher than, equal to, or lower than the qualifying payment amount, as calculated by CHLIC (“QPA”). Patient cost-share will be based on the lower of the QPA, the non-Participating Provider’s billed charges, the amount determined by CHLIC to be required by state law (if applicable), or the Initial Allowed Amount. Patient cost-share will not increase as a result of negotiations or independent dispute resolution determinations under the No Surprises Act. If additional payment above the Initial Allowed Amount is owed as a result of negotiations or independent dispute resolution under the No Surprises Act, CHLIC, as agent for the Employer, shall make Bank Account Payments from the Bank Account in the amount of such additional payment.</td></tr>
<tr><td colspan="3">Non-Participating Provider Cost Containment Programs for NSA Services</td></tr>
<tr><td>1.</td><td>Network Savings Program</td><td>29% of net savings</td></tr>
<tr><td>2.</td><td>Supplemental Network</td><td>29% of net savings</td></tr>
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<tr><td></td><td>Outpatient Hospital Bill Review</td><td></td></tr>
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</table>

	• Line Item Analysis Re-pricing	**29% of net savings**
	Physician/Professional Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
4.	Payment based on amounts other than Network Savings Program, Supplemental Network, and Medical Bill Review. These payments include amounts determined through negotiation or independent dispute resolution under the No Surprises Act. (The charges indicated in the column to the right include the fees charged by government departments or agencies for administering the independent dispute resolution process and the fees charged by entities conducting independent dispute resolution.)	**29% of net savings**
C. Other Cost Containment Programs		
1.	Clinical Complex Claim Review – (Pre- or Post-payment Cost Containment for Non-contracted and Contracted claims):	
	• Bill Audit	**29% of the gross savings/gross recovery achieved plus hospital fees or expenses passed through**
	Diagnosis Related Grouping (DRG) Validation/Audits and Recovery. An overpayment audit and recovery program in which CHLIC or its vendors review paid claim data to identify overpayments based on inaccurate DRG coding.	**29% of gross savings/gross recovery plus any fees or expenses passed through by the hospital or regulatory agency**
	• Medical Implant Device Audits	**29% of the gross savings/gross recovery**
2.	COB Vendor Recoveries [Exclusive of pharmacy programs where claims are adjudicated at time prescription is received.]	**29% of the gross recovery**

3.	Secondary Vendor Recovery Program	**29% of the gross recovery**
4.	Provider Credit Balance Recovery Program	**29% of the gross recovery**
5.	High Cost Specialty Pharmaceutical Audits (this service is only provided with respect to Medical coverage)	**29% of the gross recovery**
6.	Eligibility Overpayment Recovery Vendor Services. Identification and recovery of funds in situations where the overpayment is due to the late receipt of Member termination information. (This service is only provided with respect to Medical coverage).	**29% of the gross recovery**
7.	Class Action Recoveries	**35% of the gross recovery**
8.	Subrogation/Conditional Claim Payment. Identification, investigation and recovery of claim payments involving other party liability or where another entity is responsible for payment (including by way of example but not by limitation automobile insurance, homeowner insurance, commercial property insurance, worker's compensation). (This service is only provided with respect to Medical coverage.)	**5% of the gross recovery plus litigation costs if counsel is retained and an appearance is filed on behalf of CHLIC or Employer in any litigation, or a lawsuit is filed on their behalf;** **29% of the gross recovery if no counsel is retained and in all other instances, including cases where state law requires that employee benefit plans be named as party defendants or involuntary plaintiffs.**

EMBARC BENEFIT PROTECTION® A NETWORK SOLUTION FOR CERTAIN HIGH-COST GENE THERAPY DRUGS		
Embarc Benefit Protection	To provide financial protection from the high cost, CHLIC has contracted with an affiliate, eviCore ("eviCore" refers to eviCore healthcare MSI, LLC d/b/a/ eviCore healthcare and certain of its affiliates), to arrange for the provision of the following gene therapy drugs for Members when both drugs are covered by the Plan administered by CHLIC, and medically necessary (as determined by CHLIC) to treat the conditions indicated: i. Luxturna® to treat inherited form of progressive blindness ii. Zolgensma® to treat children under 2 years old with spinal muscular dystrophy Additional drugs are continually being evaluated and may be added to the network solution after FDA approval. The complete list of included drugs can be found at Cigna.com. (Luxturna is the registered trademark of Spark Therapeutics, Inc. and Zolgensma is the registered trademark of Novartis, Inc.) As a result of this network contracting arrangement, eviCore is in most cases the exclusive, in-network Participating Provider of these drugs. eviCore arranges for the provision of these drugs through its network of specialty pharmacies (including its affiliate, Accredo), and certain facilities authorized to administer the gene therapies by the drug manufacturers. eviCore will reimburse these specialty pharmacies and facilities at negotiated reimbursement rates. This network solution is called Embarc Benefit Protection. For arranging for the provision of these drugs, eviCore will be reimbursed by CHLIC on a fixed Per Member Per Month (PMPM) basis. eviCore's PMPM fee (which is subject to change) will be charged to the Bank Account one month in arrears. (e.g., eviCore's charges for January will be made in February.) These Bank Account Payments will appear in Employer's monthly reporting. Embarc Benefit Protection does not provide financial protection from the cost of administering the two drugs. These costs are small in comparison to the drug costs. When covered under the Plan and determined by CHLIC to be medically necessary for the treatment of the specified conditions, Members will not incur any out-of-pocket costs for the two drugs and the Plan will not be required to reimburse any expenses for the two drugs	**$0.99 per Member/per month.** If, across eviCore's entire Embarc Benefit Protection book of business (Cigna and non-Cigna clients), eviCore's cost for the two (2) drugs provided in a given calendar year is lower than a predetermined percentage of the PMPM charges received, eviCore will refund the difference pro rata, after having fully recovered the outstanding balance created by any prior year deficits. The refund, in any, will be determined on an eviCore Embarc benefit Protection book-of-business basis. The refund will be provided by March 31st of the following year. Assuring Transparency: After the refund is made for a particular calendar year, eviCore will, upon request, provide Embarc

	with two exceptions: <u>Exceptions</u>: 1. For Members born before the date that Embarc Benefit Protection is effective for the Plan and receiving Zolgensma,® the Plan's in-network reimbursement and the Member's in-network cost-sharing apply to either (as applicable): • eviCore's fee-for-service charge for Zolgensma® when provided through Accredo: Average Wholesale Price (AWP) minus 15.8% AWP (based on Medispan) = $2,550,000, or • the reimbursement rate of the participating facility or specialty pharmacy. 2. Members with an HSA must have met the applicable minimum deductible required for a high deductible health plan. **eviCore's Embarc Benefit Protection and PMPM charge do not apply to a plan that:** i. does not cover either or both drugs; ii. covers both drugs exclusively under its pharmacy benefits which are not administered by CHLIC, or iii. does not utilize an eviCore participating provider. Upon Employer's request on or after the Effective Date, CHLIC shall provide to Employer an updated drug list, if applicable. CHLIC may revise charges/fees by giving Employer at least thirty (30) days' prior written notice.	Benefit Protection book-of-business information for that calendar year.

CARE MANAGEMENT/COST CONTAINMENT PROGRAM FEES		
	CHLIC arranges for third parties to provide care management services to: (i) contain the cost of specified health care services/items overall with respect to all plans insured and/or administered by CHLIC, and/or (ii) improve adherence to evidence based guidelines designed to promote patient safety and efficient patient care. Charges for these services will be processed through the Bank Account.	**Specific vendor fees and care management program services are available upon request.**
	Medical Management (inclusive of Medical Necessity Review) of Chiropractic services.	**National Average is $0.16 PMPM; rates vary by market and are available upon request.**
	Care coordination of in-home hospital level care (acute and post-acute Plan Benefits) provided by Participating Providers. The per episode charge is subject to adjustment based on vendor achieving or not achieving total cost of care savings, upon post-episode reconciliation. Vendor's fee is distinct from payment for Plan Benefits.	**Per episode charge may vary by market. Vendor, program information, and agreed upon rates available upon request.**
	In addition to such third parties, CHLIC has arranged for an affiliate, eviCore, to provide the following care management/cost-containment programs:	
	Pre-certification of coverage of radiation therapy services.	**$912.00 per episode of care (EOC)**
	Pre-certification of coverage of diagnostic cardiology services. *(If Employer has elected Basic Standard Medical Management (see Administration Charges section above) this program and charge is not applicable to that membership).*	**$0.19 PMPM**
	Pre-certification of coverage of medical oncology services.	**$1,050.00 per episode of care (EOC)**

	Pre-certification of coverage of musculoskeletal therapy services. *(If Employer has elected Basic Standard Medical Management (see Administration Charges section above) this program and charge is not applicable to that membership).*	**$0.40 PMPM**
	Services related to the coverage of high tech radiology which may include pre-certification. In certain instances, the Plan will pay eviCore a fee on a per member/per month basis for pre-certification, arranging care, and other services that eviCore may render. Such reimbursement will be in addition to the amount that the Plan pays to reimburse the provider through which eviCore arranged for the provision of the service or supply, which will be based on eviCore's contracted rate with that provider. In such instances, Plan Benefits and member cost-share will be determined based on the rate that eviCore contracted to pay the provider for the provision of the service or supply. *(If Employer has elected Basic Standard Medical Management (see Administration Charges section above) this program and a charge is not applicable to that membership).* eviCore may also charge for services related to the provision of high tech radiology as described below in "Other Vendors and Health Care Services Providers."	**Fee reimbursement method and rates may vary by market and are available upon request**.
	Pre-certification of coverage of gastroenterology services. *(If Employer has elected Basic Standard Medical Management (see Administration Charges section above) this program and charge is not applicable to that membership).*	**$0.09 PMPM**
	Pre-certification of coverage for appropriate setting of care/service for high tech radiology services *(If Employer has elected Basic Standard Medical Management (see Administration Charges section above) this program and charge is not applicable to that membership).*	**No more than $0.20 PMPM. Billing method may vary by market and is available upon request.**
	Pre-certification of coverage for appropriate setting of care/service for certain medical oncology drugs (redirection may be to Accredo, a CHLIC affiliate).	**30.00% of shared savings (where savings is derived from the difference between drug dose cost at higher**

		cost provider initially requested and drug dose cost at lower cost provider). Fee shall not exceed $5,000.00 per dose for a maximum of three doses resulting in a maximum total of $15,000.00. Note: CHLIC may retain a portion of the shared savings fee before reimbursing eviCore.
	Pre-certification of coverage of sleep management services. *(If Employer has elected Basic Standard Medical Management (see Administration Charges section above) this program and charge is not applicable to that membership).*	**$0.11 PMPM**
	Network management and care coordination of coverage of home health, durable medical equipment and home infusion services.	**$0.31 PMPM**
	CHLIC may revise charges/fees by giving Employer at least sixty (60) days' prior written notice.	
EXTERNAL REVIEW AND CONSULTATIVE REVIEW FEES		
	When a Member elects an External Review (as that term is defined in the Patient Protection and Affordable Care Act (PPACA)) of a benefit determination by an independent third party, the cost of a specific third party review is dependent on the nature and complexity of the issue on appeal. Third party review charges will be commensurate with the level of expertise necessary and the time required to complete the review.	**$500-$1,500 Review**

STRATEGIC ALLIANCES		
	CHLIC contracts directly or indirectly with other managed care entities and third party network vendors for access to their provider networks and discounts. These third parties charge a network access fee, which is included in CHLIC's monthly charges, as a result of the application of their discounts. Additional details regarding specific charges will be provided upon request.	**All Medical Products**
OTHER VENDORS AND HEALTH CARE SERVICES PROVIDERS		
	The fixed per person per period and/or fee-for-service charges that CHLIC has directly or indirectly negotiated with Participating Providers for in-network health care services and/or supplies will be charged to the Bank Account and will be used in calculating any applicable Member cost-sharing. In addition, performance-based payments to Participating Providers will be charged to the Bank Account. Such payments will be at the payment rates then in effect, which may be amended from time to time. For certain types of specialty care, including, but not limited to, home health care, durable medical equipment, sleep management, high tech radiology, chiropractic care, acupuncture, physical medicine (such as physical and occupational therapy), speech therapy, orthotics and prosthetics, implants, and hearing, in certain markets CHLIC may contract with various third parties and/or affiliated companies, including eviCore, ("Specialty Vendors") to arrange for the provision of care through their own networks of health care providers on a fee-for-service basis. In addition to arranging for care through their own networks of providers, these Specialty Vendors may also provide additional services, including utilization management services and case management services designed to (i) improve adherence to coverage guidelines; and (ii) contain overall healthcare costs to the Plan. Specialty Vendors are included within the definition of "Participating Provider" set forth in this Agreement and in any benefit booklet covering the Plan. When care is arranged through a Specialty Vendor's network of providers, the form of reimbursement to the Specialty Vendor will be through one of the following methods: • <u>Fee-For-Service Payment</u>: In certain instances, the Plan will pay the Specialty Vendor rather than the treating provider on a fee-for-service basis as a claim for Plan Benefits. The Specialty Vendors' fee-for-service charges may be higher than the amounts that the Specialty Vendor contracts to pay the provider for the provision of any particular	**All Products**

	service or supply, and some portion of the Specialty Vendor's charges may be attributable to the services that the Specialty Vendor provides in addition to those services or supplies provided by the Specialty Vendor's network of providers, including any utilization management services and case management services. In such instances, Plan Benefits and member cost-share will be determined based on the Specialty Vendor's charges according to Plan terms. • Administration Capitation Payment: In certain instances, the Plan will pay the Specialty Vendor a fee on a per member/per month basis for arranging care and other services that the Specialty Vendor may render. Such reimbursement will be in addition to the amount that the Plan pays to reimburse the provider through which the Specialty Vendor arranged for the provision of the service or supply, which will be based on the Specialty Vendor's contracted rate with that provider. In such instances, Plan Benefits and member cost-share will be determined based on the rate that the Specialty Vendor contracted to pay the provider for the provision of the service or supply. • All-Inclusive Capitation Payment: In certain instances, the Plan will pay the Specialty Vendor a fee on a per member/per month basis that covers (i) the services that the Specialty Vendor may render, including arranging care, and (ii) the fees charged by the provider through which the Specialty Vendor arranged for the provision of the service or supply. In such instances, Plan Benefits and member cost-share will be determined based on the rate that the Specialty Vendor contracted to pay the provider for the provision of the service or supply. CHLIC's arrangements with Specialty Vendors are subject to change at any time, and upon request, additional information can be provided that identifies current Specialty Vendors, their area of specialty(ies), whether they are CHLIC affiliates, and the form of payment that they currently receive.	
	Notwithstanding the terms of the Plan, CHLIC shall not administer Member cost-sharing with respect to charges made by Cricket Health, Inc. for its personalized, evidence-based approach to managing chronic kidney disease and end-stage renal disease for clinically eligible Members in CA and such cost-sharing expenses shall, instead, be reimbursed by the Plan (not applicable if Employer has opted out).	**All Products (excluding HSA Products)**

	NOTICE REGARDING PAYMENTS FROM THIRD PARTIES	
Rebate and Other Remuneration Disclosure (Medical)	CHLIC may directly or indirectly receive and retain payments under contracts with pharmaceutical manufacturers or third parties with respect to Members' utilization of the manufacturer's products covered under the Employer's Plan medical benefit. These payments may include rebates, service fees (e.g. administrative fees), or other remuneration. CHLIC directly or indirectly contracts with pharmaceutical manufacturers or other third parties for any remuneration on its own behalf, based on its book of business, and for its own benefit, and not on behalf of Employer or the Plan. Accordingly, CHLIC retains all right, title and interest to any and all such remuneration received from manufacturer; neither Employer, its Members, nor Employer's Plan retains any beneficial or proprietary interest in any such remuneration, which shall be considered part of the general assets of CHLIC. This provision shall survive termination or expiration of the Agreement.	**All Medical Products**
Implementation/Referral Fee Disclosure	From time to time, CHLIC, directly or through its affiliates, arranges with third parties (e.g., service vendors, provider network managers) to provide various services (e.g., cost-containment services or health care services) in connection with the Plan. CHLIC and its affiliates may receive payments from such third parties to help defray CHLIC's expenses associated with its implementation and/or ongoing administration of these arrangements or as a reimbursement for services or network access provided to such parties by CHLIC. CHLIC may also receive compensation from third-party vendors that Employer may retain based upon a referral from CHLIC or that Members may utilize following an introduction facilitated by CHLIC or an affiliate. CHLIC may also receive: • network administration fees from some providers participating in its provider network, • credits from banks on balances in accounts utilized to administer claims, • non-material incidental compensation/benefits from other source as a result of administering the Plan.	**All Products**

COMPLIANCE ASSISTANCE		
	CHLIC shall provide the following services to assist Employer in meeting its compliance obligations under section 2715 of the Public Health Service Act as added by the Patient Protection and Affordable Care Act and applicable regulations with respect to the provision of the Summary of Benefits and Coverage ("**SBC**"), translation notice and glossary. Applicable to all medical plans including HRA and FSA which are considered "group health plans" subject to the SBC requirements.	
1.	Preparation of SBC, translation notice. CHLIC will not be responsible for any changes that Employer makes to the SBC.	**No charge**
2.	Provide SBC, translation notices prepared by CHLIC to Employer electronically as well as any updates or material modifications.	**No charge**
3.	Include in SBC a summary of benefits administered by carve-out vendor if Employer or carve-out vendor provides CHLIC with necessary carve-out benefit information at least twelve (12) weeks prior to the date the SBCs are to be delivered to Employer.	**$500 for each benefit option under the Plan for which carve-out vendor benefits are included in SBC**
ADDITIONAL SERVICES		
Service	**Description**	**Charge**
Behavioral Health	Access to inpatient and outpatient behavioral health services and focused utilization review and case management for both inpatient and outpatient, in-network behavioral health services. When applicable, only to Members in CA/VI.	**For HRA OAP,** **OAPIN** **and OAP Products: Included in Medical Access Fee**
Health Advisor - A	The Health Advisor program focuses on engaging targeted Members related to a variety of wellness and prevention topics, and is designed to facilitate healthy behaviors and promote achievement of health-related goals. The program includes the following components: • Health and wellness coaching on high blood pressure, high cholesterol, healthy eating,	**For OAPIN** **and OAP Products: Included in Medical Access Fee**

	physical activity, and pre-diabetes using multiple coaching sessions, behavior modification techniques and other motivational interviewing and coaching styles to encourage behavior change that helps Participants reach established goals. • Education and referral coaching on program topics with referral to appropriate internal and external resources available. • Access to educational materials and web-based Member tools and resources. • Identification of gaps in care and outreach to Member to provide coaching for those identified with gaps for high cholesterol, high blood pressure, and additional coaching on other gaps in care will also occur. • Support of Participants identified through predictive modeling with certain preference sensitive care conditions by supplying impartial evidence based medical information, to empower Participants' to understand the potential benefits/ disadvantages of a specific course of action and make more informed care decisions. This feature is only available when claim data is provided. • Answering health and medical related questions. • Counseling Participants on prevention and the benefits of compliance with prescribed medications and treatments.	
Clinical Program	A targeted condition medication therapy management program in which CHLIC provides support for Members using specialty medications for certain chronic conditions and that are obtained or administered at retail pharmacies or outpatient, office or home health care settings. As part of the program, Members are counseled on their condition, medication side effects, and importance of adherence. For the sake of clarity, if a specialty pharmacy affiliate of CHLIC provides therapy management for specialty medications the pharmacy dispenses to Members, then it does so in its capacity as a specialty pharmacy and not on behalf of CHLIC; CHLIC does not exert direction or control over the pharmacists at any specialty pharmacy affiliate.	**Included at No Additional Cost**

Employee Assistance Program (EAP)	CHLIC provides the Employee Assistance Program Services ("EAP") for EAP Participants through its affiliate (details available upon request) experienced in establishing and administering an EAP ("CHLIC's Affiliate"). The clinical component of the EAP provided to EAP Participants who reside in California or Nevada is covered under the short-term counseling policy(ies) issued to Employer by CHLIC and not by the terms of this contract. All other EAP services for such EAP Participants are covered by the following terms. **EAP Participant:** Any person who is eligible to receive EAP Services provided pursuant to this Agreement, including Employer's employees, their dependents and members of employees' households. **Clinical Services:** For mental health, alcoholism or substance use disorder services ("Clinical Services"), assessment, referral and/or short-term problem resolution sessions will be provided, up to ten (10) visits per assessed problem. **Information Support Services:** For family care, legal/financial information, Healthy Rewards® discounts, online resources, and assessment and referral services as requested by EAP Participant or Employer will be provided. Legal assessment and referral services are not available to EAP Participants if the issue is related to a potential cause of action against Employer. Any additional services ("Menu Options") purchased by Employer are listed below. Services shall be provided by CHLIC's Affiliate through its employees, contracted specialty firms and/or independent contractors. EAP Participant calls to the toll-free number shall be handled by a personal advocate who shall refer the EAP Participant to an appropriate resource. a) For Clinical Services, an appointment shall be offered within two (2) business days with a local counselor. In a Clinical Services' emergency, trained clinicians shall be available to telephonically address the situation and to make a referral to a local counselor or crisis intervention center for assessment referral and/or short-term problem resolution. b) For Information Support Services, EAP Participant may be referred to contracted	**Effective 1.1.23:** **Emergency Responder Line:** $600/year (included in the fees Employer pays CHLIC) EAP fees for Members eligible for CHLIC medical benefits and for Members who are eligible for non-CHLIC medical benefits are billed CHLIC's Affiliate as follows: **1-10 Clinical Services and Information Support services:** $2.20/employee/month

	specialty firms or to local resources for assessment and referral. Legal and/or financial services shall include, at no charge to EAP Participants, an initial thirty (30) minute consultation. EAP Participants shall be responsible for all other costs of services provided pursuant to a referral. Contracted specialty firms might offer the EAP Participant a discount rate. For Clinical Services, CHLIC's Affiliate shall maintain a nationwide network of local mental health and substance abuse counselors who shall assess the problem, provide short-term problem resolution and/or guide the EAP Participant to appropriate local treatment resources. Fees for Clinical Services other than assessment, referral and short-term problem resolution services within the maximum number of ten (10) visits per assessed problem shall be the EAP Participant's responsibility. CHLIC's Affiliate shall not represent to the EAP Participant that identification of or referral to treatment resources constitutes coverage under the provisions of EAP Participant's medical coverage plan. Communication materials related to EAP services are available electronically. Other EAP services that shall be provided include: a) Reports concerning utilization of EAP services by EAP Participants on a quarterly basis to Employer. Individually identifiable EAP Participant information shall be the property of CHLIC's Affiliate. Without the appropriate written consent of the EAP Participant, no information shall be provided to Employer or any third party that includes any EAP Participant specific identifiable information. Due to the sensitivity of EAP services, this provision is intended to be more stringent regarding the use or disclosure of PHI by CHLIC and/or its other affiliates than the Business Associate Agreement and as such, this paragraph shall prevail over any other provision in the Agreement or any of its Schedules or Exhibits and/or their Attachments. b) Management consultations to supervisors who request assistance for work related problems of employees. CHLIC's Affiliate shall provide assistance with mandatory referrals for employees who are required, under continuation of employment, drug-free workplace or other workplace policies, to receive an	

	assessment under the EAP. However, CHLIC's Affiliate shall not nor shall any of its network of providers provide advice and/or make a determination regarding an employee's (a) ability to safely perform the functions of his/her job, (b) ability to return to work after a medical disability, involuntary suspension from duties or administrative leave of absence, and/or (c) potential for workplace violence. No individually identifiable employee information concerning the employee's treatment shall be provided without the employee's written consent on an approved form. c) Employer Account Services: As part of EAP fees, Employer has purchased a number of hours for each twelve (12) month period from the effective date of this Agreement for use in the delivery of the following Employer Account Services: (a.) Employee Orientation Sessions; (b.) Management/Supervisory Training sessions; (c.) Educational/Wellness Seminars; (d.) Critical Incident Response Services; and/or (e.) Other Employer Account Services, e.g. Employer Account Services requested by Employer for which CHLIC's Affiliate notifies Employer that those services shall be counted against Employer Account Services' hours, including but not limited to, executive briefings, reduction in workforce counseling, and Employer's on-site EAP promotional activities conducted by EAP managers or contracted EAP affiliates. The number of hours to be provided by CHLIC's Affiliate for Employer Account Services in each twelve (12) month period shall be **2 hours per 1,000** employees based on the number of employees reported by Employer on the first bill for that period. Pro-rata adjustments in this number of hours may be computed pursuant to Section 8 of the Agreement. Delivery of these Employer Account Services shall be as agreed upon by CHLIC's Affiliate and Employer. In the event Employer does not utilize or only partially utilizes these Employer Account Services during the twelve (12) month period to which they relate, Employer shall not be entitled to any refund or account credit, or to carry those hours forward. If Employer cancels its request for these services or reduces the number of hours initially requested after an independent provider has been secured, CHLIC's Affiliate shall deduct that number of hours the provider had been secured from Employer Account Services' hours. Additional Employer Account Services' hours may be purchased by Employer at the then current fee-for-service rates in effect as of the date of request of such additional Employer Account Services' hours. Delivery of these additional Employer Account Services shall be as agreed upon by	

	CHLIC’s Affiliate and Employer. Employer shall: a) Provide information to Participants regarding access to the communication materials described above, and shall cooperate in other reasonable efforts to otherwise communicate with EAP Participants concerning the services available to them pursuant to this Agreement. b) Inform CHLIC’s Affiliate of Employer’s management policies and procedures that guide supervisors in handling employees with performance concerns in order for the training described above in Employer Account Services to be provided. CHLIC’s Affiliate assumes no responsibility for the legal appropriateness of such policies and procedures. c) Annually, within ninety (90) days of the anniversary date of this Agreement, furnish the number of employees who are only EAP Participants by state of residence. Such number would not include employees who are EAP Participants who also have coverage for Mental/Health Substance Abuse services under the Plan. **MENU OPTIONS** **Effective 1/1/2023:** Emergency Responder Line	
Incentive Tracking for Management Wellness Plan	The City has a Management Wellness plan that provides management employees with a $500 incentive based on completion of the defined activities. Cigna agrees to track incentives for the City, however the City will indemnify Cigna and hold it harmless from and against all contractual or extra contractual claims, amounts, liabilities, reasonable costs and/or expenses (including attorney’s fees and court costs) which Cigna or the City may incur in connection with such tracking or in connection with any judicial, quasi-judicial or administrative proceedings relating thereto.	

Your Health First	A proactive health education and improvement program for Members with a chronic condition. The program involves services that span across the Member's health needs. Behavioral coaching principles and evidence based medicine guidelines are utilized to optimize self-management skills and foster sustained health improvements. The program targets a chronic population at high risk for near term and future high cost medical expenses. Members are identified as having a chronic condition through a variety of sources which may include: claims data, referrals, and self-identification. A variety of resources is provided to those with a chronic condition, including access to online tools, personalized support, and targeted materials. The program includes the following components for those with a chronic condition: • Chronic condition-specific coaching • Pre- and post-discharge calls • Lifestyle management coaching: stress, weight management and tobacco cessation • Treatment decision support and coaching	**For HRA OAP,** **OAPIN** **and OAP Products: Included in Medical Access Fee**
Motivate*Me*® Incentives Program	The Motivate*Me* incentive program allows employers to reward Members for taking steps to achieve health goals or make progress towards improving their health. Participating Members can earn rewards for active participation in CHLIC's health improvement programs and activities that focus on prevention, lifestyle and behavior modification and disease management. Participating Members track their incentive activity online and earn rewards as has been designated per the Employer's annual elections. Reward types include: HRA and Healthy Awards Account fund deposits, debit and/or gift cards, and Employer self-administered awards such as HSA fund deposits, healthcare premium adjustment and payroll deposit.	
	Engage Package - includes administration of Employer selected CHLIC standard Incentives Program which provides Participating Members with Employer's pre-determined rewards. Activity to trigger incentives may include, but is not limited to, participation in	**For OAPIN (MMe selection: OAME1,OAME2,**

	the following available programs: Personal Health Analysis (CHLIC's health assessment), Social Health and Wellness, Wellness Screening (biometric), Online Health Coaching, Pre-Diabetes Digital Coaching, Self-Reported Activities, Steerage (Cigna Home Delivery, Cigna Care Designation, Cigna's Center of Excellence facility steerage), Health Coaching by Phone, Case Management, Preventive Care (claim verified), Employer specific programs and Achieve Health Goals (biometric outcomes).	**OANM1, OANM2, ONM1F, ONM1L)** **and HRA OAP (MMe selection: HRAEM, HRAM1, HRAM2) Products: Included in Medical Access Fee**
One Guide	The One Guide advocacy solution utilizes a multimodal approach to support members and help them successfully navigate the health care system. members are serviced by personal guides that include frontline service staff, as well as clinicians and non-clinician support staff from our medical, behavioral and pharmacy programs. In addition to connecting with personal guides via telephone, members can also interact with personal guides via the click-to-chat feature on myCigna.com (web and app), enabling members to engage with CHLIC and One Guide in the way in which they prefer. One Guide helps simplify and strengthen the connection between members, their benefit plan, and their overall health and well-being. Through personalized and relevant messaging, One Guide proactively engages members with clear ways to save money, stay healthy, and improve health outcomes that lead to a healthy lifestyle. One Guide offers: • education on health plan features, account balances and ways to maximize benefits and earn available incentives • guidance in finding the right doctor, lab, convenience care or pharmacy • immediate connection to health coaches and other resources The goal of One Guide is to help Members take care of what matters most- staying healthy, saving money, and improving health.	**For OAPIN,** **OAP** **and HRA OAP Products:** **$3.50/employee/month Included in Medical Access Fee**

Fee Holiday	For 3 months, the Medical Administration, Network Access and One Guide (the "**Fees**") will be waived.	**Included at no Additional Charge**
Transparency in Coverage and Consolidated Appropriations Act, 2021	CHLIC will make available an internet-based self-service tool for use by Members, as well as certain data in machine-readable file format on a public website, as required under the Transparency in Coverage rule. Members can access the cost estimator tool on myCigna.com. Updated machine-readable files can be found on Cigna.com and/or CignaForEmployers.com on a monthly basis. Pursuant to Consolidated Appropriations Act (CAA), Section 106, CHLIC will submit certain air ambulance claim information to the Department of Health and Human Services (HHS) in accordance with guidance issued by HHS. Subject to change based on government guidance for CAA Section 204, CHLIC will submit certain prescription drug and health care spending information to HHS through Plan Lists Files (P1-P3) and Data Files (D1-D8) (D1-D2 for employers without integrated pharmacy product) aggregated at the Market Segment and State level, as outlined in guidance.	**Included in Medical Administration Fee**
CHLIC Well-Being Coordinator		
Well-Being Coordinator	**Well-Being Coordinator** CHLIC shall provide to Employer (sometimes alternatively referred to as "Client") Well Being Coordinator Services ("Well-Being Coordinator") as described herein. Services will be restricted to health and wellness promotion topics and will exclude disease management. The following Services may be modified in the professional judgment of the Health Promotion Manager, as necessary to meet the specific needs of the Client and its employees. The Well-Being Coordinator will work closely with CHLIC's Account Management Team and Client's Health and Wellness team in executing the organizations health management goals. The primary focus of the Well-Being Coordinator is health promotion. In collaboration, with the CHLIC account team, the Well-Being Coordinator executes the appropriate delivery and coordination of wellness programs including event scheduling and appointment coordination, community and vendor programs, and monitors effectiveness of	The cost of Well-Being Coordinator is included in the Medical Administration Charge.

the programs. The focus of the Well-Being Coordinator is the working well population of employees in aggregate. A core objective of this position is to facilitate wellness programs that educate and influence employees at the worksite to lead healthy lifestyles.

If different from the Effective Date of this Agreement/Amendment/Disclosure, the effective date of Well Being Services will be: January 1, 2023

Number of Well-Being Coordinators: 1

Number of hours per week: 40 hours

Days per week: Monday - Friday

Location of Services (Client work site locations):

Fort Lauderdale, Florida

*Note: Services may at times be performed virtually, especially if requested or required due to Covid-related issues such as Covid exposure, limitations on in-person gatherings, need for quarantine or other government action or regulation.

Client shall allow Well-Being Coordinator eight (8) hours per week for resource planning, scheduling and development at a CHLIC worksite.

As a CHLIC employee the Well-Being Coordinator participates in regular CHLIC meetings trainings and development opportunities with the Health Promotion and Account Management Team. Client shall allow Well-Being Coordinator time for these activities each week.

Well-Being Coordinator Services

Wellness Promotion

1. Collaborate and facilitate with the Client Wellness Committee
2. Wellness Education Courses

	3. Wellness Education Seminars 4. Wellness Campaigns 5. Wellness Event/Fair 6. Wellness Resources	
	General Responsibilities 1. Workplace strategy in partnership with customer Human Resources team and/or Benefits team. a. Partner with Client for development of overall planning and strategy b. Identify organizational goals and workforce risk c. Collaborate on tactics to bring the strategy alive d. Maintain activity calendar of events and activities 2. Lead Client Wellness Committee a. Collaborate with the Client on the formation of a wellness committee if one has not already been established and include different levels of Client leadership and employees from the worksite b. Ongoing collaboration and facilitation of Client Wellness Committee c. Review the proposed health promotion strategy with the wellness committee, partnering with CHLIC lead for health and wellness as appropriate. The strategy will be developed by the CHLIC account team lead for health and wellness. 3. Collaborate in development and delivery of promotion campaigns a. Partner in overall promotion development and deployment b. Identify ways to embed wellbeing into the environment c. Identify or craft health promotion communications	

	d. Create awareness and visibility for wellness 4. Health Education Courses a. End to end coordination of educational courses b. Deliver single or multi-session workshops on a group basis (lunch and learn) c. Develop or pull from defined list of wellness topics; may be tailored to population, season, etc. d. Education for various health related topics (nutrition/healthy eating, physical activity, etc.) 5. Wellness Campaigns a. Facilitate health related group activities among population over a defined time period (walking groups, weight loss support groups etc.) b. Focus campaigns and challenges on lifestyle habit change/improvement c. Coordinate with a variety of vendors to bring services onsite on a routine basis who provide health related products and services to engage associates. 6. Wellness Event/Fair a. Facilitate coordination of wellbeing event/fair b. Assist with coordination of activities, biometrics, online Health Assessment, individual and team challenges, guest speakers, mammogram screening, open enrollment, family wellness event, etc. 7. Wellness Resources a. Manage wellness bulletin board and electronic media board b. Share health and wellness related educational materials	

	8. Travel a. Occasional travel expectation to identified locations within the organization for well-being purposes	
	Qualifications The Well-Being Coordinator will have: 1. Minimum of 2-5 years of experience in health and wellness field 2. Industry Certification such as CHES worksite wellness certificate or other relevant certification 3. Bachelors' degree in health education, health promotion, or related field 4. Experience with workplace well-being strategy and implementation 5. Experience with design of workplace infrastructure and engagement solutions 6. Experience with direct member communication development (written and verbal) 7. Experience conducting educational presentations 8. Experience working with wellness and health data to identify trends, risks and program results 9. Strong organizational and project management skills	
	Paid Time Off and Leave The Well-Being Coordinator shall be entitled to paid time off (PTO) and other leave ("Leave") in accordance with CHLIC's standard policies and procedures ("Policies"). PTO shall include: (a) vacation days; (b) personal days; (c) holidays; (d) floating holidays; (e) sick leave; and (f) other PTO in accordance with applicable law and current CHLIC Policies. Leave shall include: (a) military leave; (b) Family Medical Leave (FMLA); (c) disability leave; and (d) other leave in accordance with applicable law and current CHLIC	

	Policies. CHLIC shall not be required to make any adjustments to Fees for PTO and Leave granted to the Well-Being Coordinator. In the event that Well-Being Coordinator is absent for an extended period of time due to military leave, FMLA, disability leave or any other Leave as defined under the current CHLIC policies and practices, the Parties shall discuss and mutually determine if CHLIC should reasonably attempt to find a temporary substitute. In the event that no substitute is placed, CHLIC shall prorate the fees for the Well-Being Coordinator. However, if a temporary substitute is placed, Client shall be responsible for the payment of any temporary labor fees, and recruitment costs. CHLIC shall not be required to find a temporary substitute or prorate the fees for a Well-Being Coordinator due to any of the following: 1. PTO; 2. Sick time not considered as short term disability under the current CHLIC policies; 3. Closure of the Client's work site(s) within which the Well-Being Coordinator provides services under this Agreement, due to inclement weather, acts of nature, or acts of the public enemy; and 4. Short term disability or caregiver leave for which the Well-Being Coordinator **is** paid.	
	Equipment CHLIC's obligation is specifically conditioned upon Client providing the following equipment and supplies necessary for the Well-Being Coordinator 1. Office space or cubicle with electrical outlet 2. Standard office furnishings (desk, chair, etc.). 3. Locking file cabinet. 4. Telephone land line within Client network 5. High Speed Internet Access equipment and services necessary for effective and efficient CHLIC vpn and wireless telephone connectivity.	

	6. Dedicated Client DSL line OR Open DSL line 7. Client desktop computer connected to Client network, if Client required 8. Client printer connected to Client network, if Client required CHLIC will provide the following equipment and supplies necessary for Well-Being Coordinator 1. CHLIC laptop and vpn for connectivity to CHLIC network 2. CHLIC printer and supplies 3. CHLIC cell-phone	
	Termination Either Party may terminate the services of the Well-Being Coordinator for cause by giving the other Party ninety (90) days advance written notice. Either Party may terminate the Agreement upon ten (10) days' written notice to the other Party upon the other Party's financial insolvency.	
	Non-Solicitation and Confidentiality of Information During the term of the Agreement, and for a period of one (1) year after termination of the Agreement for any reason, Client shall not directly or indirectly, alone or in concert with others, solicit or entice the employee or independent contractor engaged by CHLIC to provide services under this Agreement, to leave the employment or engagement of CHLIC in order to provide substantially similar services as those provided in the Agreement, to or on behalf of Client, or to otherwise work in competition with CHLIC. The Client agrees and acknowledges that the Well-Being Coordinator will have access to proprietary and confidential information of CHLIC. The Client agrees that any proprietary and/or confidential information of CHLIC that is utilized by the Well-Being Coordinator in these services shall only be used for the purpose of performing these services, and for no	

	other purpose. The Client agrees that such proprietary and/or confidential information will not be shared internally by Client with any employee who does not have a need-to-know such information for the performance of these services. This shall include a prohibition on Client cooperating with or allowing a third party to hire a CHLIC employee to work for the third party to provide substantially similar services as those provided in the Agreement.	
	No Co-Employment The services of the Well-Being Coordinator are those of an independent contractor and/or employee and/or agent engaged by CHLIC. Well-Being Coordinator shall not in any sense whatsoever be deemed an employee or agent of Client or authorized to commit Client to any liability or obligation whatsoever. The Well-Being Coordinator shall not look to Client for health or life insurance, vacation pay, sick leave, retirement benefits, social security, worker's compensation, disability or unemployment insurance benefits or any other benefits. Client will not withhold taxes from the compensation paid to Well-Being Coordinator hereunder and shall not be responsible for any employer portion of taxes on any compensation paid to the Well-Being Coordinator.	
	CHLIC Staffing CHLIC shall recruit, interview, engage, hire, supervise and discharge any provided Well-Being Coordinator. All employment related decisions, including but not limited to hiring, firing, and performance management, shall be at the sole discretion of CHLIC and not Client. Well-Being Coordinators shall in all events, and for all purposes, be employees of CHLIC and not Client. CHLIC shall comply with all federal, state and local laws regulations and requirements relating to such employees. CHLIC, and not Client, shall be fully responsible for the payment of all salaries, wages, payroll and other compensation, taxes, fees, workers compensation insurance and other charges or insurance levied or required by any federal, state, or local law, regulation or ordinance relating to the employment of the Well-Being Coordinator. CHLIC, and not Client, shall be solely responsible for determining salaries, bonuses, and other compensation of Well-Being Coordinator.	

	Performance Management In the event that Client is dissatisfied with the performance of any Well-Being Coordinator providing Well-Being Coordinator Services hereunder, or asserts that any Well-Being Coordinator has engaged in misconduct as defined by Client or has materially failed to perform the Services in accordance with the Agreement, Client shall so advise CHLIC immediately and provide in writing the facts necessary to validate the concern or complaint. CHLIC shall promptly consult with Client as to the nature of the conduct complained of and the severity of Client's dissatisfaction, and shall endeavor to resolve such issues to the satisfaction of Client provided such resolution is not unlawful or discriminatory. Client acknowledges and agrees that the policies and procedures of CHLIC or its parent company as to the performance of Well-Being Coordinator Services shall govern, including any confidentiality requirements contained therein. Client agrees, where necessary, to cooperate with CHLIC in conducting any investigation or inquiry, and in providing documentation and testimonial support in event of litigation concerning Well-Being Coordinator misconduct or failure to perform.	
	Force Majeure Neither CHLIC and/or Client will be in default or otherwise liable for any delay or failure of its performance under this CHLIC Well-Being Coordinator section to the extent such delay or failure is due to causes beyond the reasonable control of CHLIC and/or Client, such as, but not limited to, acts of God, acts of public enemy, the elements, adverse weather conditions, fire, floods, riots, strikes, accidents, disease, pandemic, war, governmental requirement, order or shutdown, act of civil or military authority, manufacturer delays, labor or transportation difficulties, acts or omissions of transportation common carriers, or other cause beyond the reasonable control and without the fault or negligence of affected CHLIC and/or Client ("Force Majeure Event"). Additionally, Client understands that in the event of a Force Majeure Event CHLICs ability to perform in part or in total, or ability to perform onsite, may be limited to the extent required by CHLIC HR minimal standards policies for the protection of CHLIC employees.	

Health Improvement Fund		
Health Improvement Fund	For clinical/wellness/behavioral programs offered by CHLIC that are purchased, CHLIC will establish a Health Improvement Fund in the amount of $100,000.00. This fund will be used to defray the cost of CHLIC designated and arranged health and wellness improvement programs (e.g. biometric screenings, flu shots) for Employees of Employer and to reward participation in these programs. The Health Improvement Fund is a one-time credit to be used from January 1, 2023-December 31, 2023. Unused funds cannot be rolled over and CHLIC must pre-approve use of the Health Improvement Fund. The Health Improvement Fund shall be extinguished upon notice of termination of the Agreement and any fund amount not used prior to the notice of termination of the Agreement shall only be available to Employer for the purpose of funding the cost of those reimbursable services provided prior to such notice of termination.	

Exhibit B – Services

BANKING AND ADMINISTRATION		
<u>Excluding</u> Health Savings Account		
	Furnishing CHLIC's standard Bank Account activity data reports to Employer as and when agreed upon. CHLIC's administration of the Plan does not include performing obligations, if any, under state escheat or unclaimed property laws. It is Employer's responsibility to determine the extent to which these laws may apply to the Plan and to comply with such laws.	**All Products**
	If Employer has elected, pursuant to section 63 of the New York Health Care Reform Act of 1996 (section 2807-t of the Public Health Law) ("the Act"), to pay the assessment on covered lives set forth in section 63 and has consented to the conditions set forth in section 63, CHLIC shall file such forms and pay such surcharge and assessment on covered lives on behalf of Employer through the Bank Account to the extent set forth in section 63. Such obligation shall end immediately upon Employer's failure to provide any information required by CHLIC to fulfill this obligation, the failure to comply with any requirement imposed upon Employer pursuant to the Act or the failure of Employer to sufficiently fund the Bank Account. In addition, where permitted and agreed to by CHLIC, CHLIC will file applicable forms and pay on behalf of Employer and/or the Plan any assessment, surcharge, tax or other similar charge which is required to be made by Employer and/or the Plan based on covered lives and/or paid claims or otherwise in accordance with and as required by other applicable state and/or federal laws and regulations and the Bank Account will be charged for any such payments made by CHLIC. CHLIC's obligation to pay on behalf of Employer shall end immediately upon Employer's failure to sufficiently fund the Bank Account.	**All Medical Products**
CLAIM ADMINISTRATION		
<u>Excluding</u> Health Savings Account		
	Calculate benefits, check and/or electronic payments disbursed from the Bank Account. Bank Account payments will appear in Employer's standard Bank Account activity data reports.	**All Products**
	CHLIC's generic claim forms are made available to Employer and eligible individuals.	**All Products**
	CHLIC's Special Investigations Unit will investigate, pend, recommend denial of claims in whole or in part, and/or reprocess claims, as appropriate.	**All Products**
	Discuss claims, when appropriate, with providers of health services.	**All Products**

	Perform, based on CHLIC's book of business internal audits of plan benefit payments on a random sample basis.	**All Products**
	Claim control procedures reported annually in Statement on Standards for Attestation Engagements (SSAE) No. 18 Report (or any applicable successor thereto).	**All Products**
	Respond to Insurance Department complaints.	**All Products**
	Designated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Products**
	Member Explanation of Benefit ("**EOB**") statements including, when applicable, notice of denied claims, denial reason(s) and appeal rights.	**All Products (excluding Pharmacy)**
	Verify enrollment and eligibility using Member information submitted by Employer and/or its authorized agent.	**All Products**
Medical Only		
	CHLIC's generic enrollment form is made available to Employer and eligible individuals.	**All Medical Products**
	CHLIC's standard ID card with toll-free telephone number are prepared and delivered to Members.	**All Medical Products**
	Administration of subrogation/conditional Claim Payment (terms described in Exhibit E).	**All Medical Products**
Health Reimbursement Account (HRA), Healthy Awards (HA) and Healthy Future (HF) Only		
	Providing reimbursement request forms to Employer.	**HRA Products**
	Employer will make available specific funds to eligible employees enrolled in the HRA, HA and/or HF as applicable (**"Participating Members"**). At the end of each reimbursement period of the Plan Year, CHLIC shall issue payments to Participating Members (or their medical provider, if appropriate) to the extent of the maximum amount of payment allowed by Employer reduced by prior reimbursements for the same period of coverage, for the amount that is determined by it to be proper under the Plan.	**HRA Products**
	Allowable expenses for reimbursement under a HRA, HA and/or HF, as applicable, include all allowable health-related expenses, pursuant to I.R.C. Section 213 except where payment for any such products is prohibited. The Employer can further limit the allowable expenses as agreed to by the Employer during implementation.	**HRA Products**
	Account balances for Participating Members active until the end of the Plan Year will remain open after conclusion of the Plan Year for a period of one year, (the "**Run Out Period**"), so that such Participating Members can submit any remaining expenses incurred during the Plan Year.	**HRA Products**

	A Participating Member’s request to terminate his/her enrollment in the HRA, HA, and/or HF, as applicable, will continue to be processed for 90 days following termination for any expenses incurred prior to his/her termination date up to the originally selected goal amount, minus prior reimbursements.	**HRA Products**
	For reimbursement payments that are made as a result of automatic claim forwarding (“**AutoPay**”) of medical claims from a medical plan administered by CHLIC or Direct Submit Request For Reimbursement, an explanation of payment will be made available to the Participating Member. An explanation of payment is not issued for payments that are issued to a pharmacy at the point of sale as a result of AutoPay from the employee's pharmacy Plan or for any Debit Card transactions.	**HRA Products**
	Providing information on account balances and submitted claims to Participating Members calling the number on the ID card. In addition, Participating Members will have access to account information via Internet and mobile app.	**HRA Products**
	When automatic claim forwarding (“**AutoPay**”) is turned on, medical claims processed but unpaid by CHLIC will be automatically submitted for reimbursement from the HRA and/or HA Participating Member’s HRA and/or HA account. Such “rollover” claims will be processed without additional submissions by the Participating Member.	**HRA Products**
	When CHLIC takes over HRA, HA and/or HF administration mid-Plan Year, CHLIC will provide administrative services from the date the Plan information is received.	**HRA Products**
	Pharmacy claims: Eligible pharmacy expenses, under the HRA, HA and/or HF that are processed but unpaid by CHLIC may be automatically submitted ("rolled over") to the Reimbursement Accounts Claim Office for reimbursement from the Participating Member’s HRA, HA and/or HF account if the AutoPay option is enabled. Such rollover claims will be processed without additional submissions by the Participating Member. When pharmacy is covered and Cigna Pharmacy is the pharmacy vendor, the HRA, HA and/or HF will automatically pay the pharmacy through the HRA, HA and/or HF at the point of sale for all Participating Member obligations under the pharmacy Plan including deductibles, copays, and/or coinsurance obligations. A Participating Member will not receive an Explanation of Benefits for these payments.	**HRA Products**
	PLAN BOOKLET	
	Prepare and make accessible Member benefit booklet drafts to Employer.	**All Products**
	UNDERWRITING SERVICES	
	5500 Schedule C reporting.	**All Products**
	5500 Schedule A or Annual Reconciliation Disclosure reporting (when applicable)	**All Products**
	CHLIC’s standard Underwriting services: a) benefit design analysis b) projected cost analysis.	**All Products**

HIPAA INDIVIDUAL RIGHTS		
	Handling of requests from Members for access to, amendment and accounting of protected health information, and requests for restrictions and alternative communications as required under federal HIPAA law and regulations, as set out in this Agreement and its Exhibits.	**All Products**
COST CONTAINMENT		
	Maximum reimbursable charge determinations of non-Participating Provider charges for covered services.	**All Medical Products (with out-of-network benefits)**
	CHLIC's standard cost containment controls: Application of non-duplication and coordination of benefits rules and coordination with Medicare.	**All Medical Products**
	Delivery of information, as necessary, regarding standard application of non-duplication or coordination of benefits.	**All Medical Products**
	Review of medical bills in accordance with CHLIC's then current Medical Bill Review program.	**All Medical Products**
	Medical Cost Containment, as described in the Schedule of Financial Charges.	**All Medical Products**
	Annual reporting of CHLIC's standard cost containment results upon Employer's request.	**All Medical Products**
REPORTING		
	Summary reports of medical and pharmacy cost and utilization experience (where applicable), upon completion of internal report generation, are available through Cigna's web site, CignaforEmployers.com.	**All Medical Products**
	Claim Reporting: CHLIC will provide standard banking and financial report information based upon paid claim data. CHLIC will not provide information on incurred-but-not reported claims, projected claims, pre-certifications of coverage, case management information or information on a Member's prognosis or course of treatment.	**All Medical Products**
	Individual Stop Loss Reporting is an optional service provided at an additional fee to employers who have individual stop loss through another entity other than CHLIC. CHLIC will provide its standard Individual stop loss reporting package, which includes banking and financial information based upon paid claims data, only after the stop loss carrier and Employer have executed CHLIC's standard Hold Harmless/Confidentiality Agreement. Aggregate Stop Loss Reporting is not included as part of the standard reporting package and is not provided. CHLIC will not provide	**All Medical Products**

	documentation and information, including but not limited to, incurred-but-not-paid claims, projected claims, pre-certifications of coverage, case management records and notes, course of treatment or prognosis, and internal audits. CHLIC does not allow stop loss carriers to audit CHLIC's claims administration under the medical benefit plan, however, the Employer's audit rights are set forth in the Agreement. For the sake of clarity, as it is possible that certain information, documentation, data and/or reports that are required by the stop loss carrier prior to reimbursement under Employer's stop loss policy will not be available for stop loss policy administration, Employer is responsible for verifying any such required information with its stop loss carrier.	
	CHLIC's standard Individual Summary Statements for applicable participating Members.	**HRA Products**
	CHLIC's standard Health Reimbursement Account, Healthy Awards and/or Healthy Future activity report for Employer.	**HRA Products**
COMPLIANCE		
	Employer directs CHLIC in administering the Health Care Flexible Spending Account, Healthy Awards, Healthy Futures and/or Health Reimbursement Account benefit to comply with COBRA as follows:	
	The HRA, HA and/or HF of each HRA, HA and/or HF Participating Member who experiences a qualifying event and elects continuation of account coverage in accordance with COBRA will be maintained similar to the maintenance of an active Employee. HF Participating Members that have not met their vesting requirements determined by the plan are not required to be offered COBRA for the HF.	**HRA Products**
MEMBER EXTERNAL REVIEW PROGRAM		
	CHLIC contracts with a minimum of three (3) independent review organizations that meet the Patient Protection and Affordable Care Act (PPACA) external review requirements. Members may appeal eligible claims requiring medical judgment to an external independent review organization which is selected by CHLIC on a random basis. If Employer has chosen not to participate in this program, the Employer may be responsible for making other arrangements to meet the Patient Protection and Affordable Care Act (PPACA) external review requirements.	**All Medical Products**
MEDICAL MANAGEMENT SERVICES		
	CHLIC provides integrated medical management that includes (depending upon the terms of the Plan) the following core services.	
	Pre-Admission Certification and Continued Stay Review (PAC/CSR) services to certify coverage of acute and sub-acute inpatient admissions/stays or provides guidance to appropriate alternative	**All Medical Products**

	settings. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	
	Case Management, a service designed to provide assistance to a Member who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support.	**All Medical Products**
	Assist providers with resources and tools to enable them to develop long term treatment plans in the management of chronic or catastrophic cases.	**All Medical Products**
	The Cigna HealthCare Healthy Babies Program is an educational program which provides Member with prenatal care education and resources to help them better manage their pregnancy. Other benefits of this program include the Health Information Line, high risk maternity and pregnancy information on myCigna.com.	**All Medical Products**
	HealthCare Cost and Quality tools available on myCigna.com and myCigna mobile app.	**All Medical Products**
	A panel of physicians and other clinicians to assess the safety and effectiveness of new and emerging medical technologies. The panel meets monthly to review and update coverage policies.	**All Medical Products**
	Health Information Line is a service that provides twenty-four (24) hour toll free access to nurses who provide convenient and confidential services. Health Information Line nurses can help guide Members in finding the right care, make informed decisions about symptom-based health issues the Member is experiencing when they call the Health Information Line and recommend appropriate settings for care. Health Information Line nurses can help inform and educate Members about a wide variety of health and medical information, including access to a library of English and Spanish podcasts.	**All Medical Products**
	Cigna LifeSOURCE Transplant Network® contracts with more than one hundred seventy (170) independent transplant facilities which includes over eight hundred (800) transplant programs and provides access to solid organ and bone marrow/stem cell transplantation while improving cost containment and reducing financial risk.	**All Medical Products**
	A health education program that delivers mailings to Members with certain conditions.	**All Medical Products**

	Behavioral health services are provided/arranged by a CHLIC affiliate (details available upon request), including utilization review and case management for both inpatient and outpatient, in-network behavioral health services.	**HRA OAP,** **OAPIN** **and OAP Products:** **(All Members)**
	Implement a quality oversight process that includes monitoring of utilization management performance measurements and a continuous quality improvement process when warranted.	**All Medical Products**
	Transition of care services to allow Members with defined conditions to continue treatment with non-Participating Providers after enrollment for continued uninterrupted care for a limited time.	**All Medical Products Except Comprehensive and Indemnity**
	Focused utilization management of outpatient procedures and identification of appropriate alternatives. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products with Care Management Preferred**
NETWORK MANAGEMENT SERVICES		
	CHLIC, and/or its affiliates or contracted vendors shall:	
	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, fixed per person per period, per diem charges, incentive bonuses, case rates, withholds etc.). The amount and type of negotiated reimbursement may vary depending upon the type of plan. For example, a hospital may accept less for patients enrolled in certain types of plans than others. In addition, CHLIC may contract with Participating Providers and other parties (for example Independent Practice Associations) for performance-based incentive payments to promote quality of care, patient safety and cost efficiency.	**All Medical Products**
	Credential and re-credential Participating Providers in accordance with CHLIC's credentialing requirements and ensure that third-party network vendors credential/re-credential Participating Providers in accordance with CHLIC's requirements;	**All Medical Products**
	Monitor Participating Provider compliance with protocols and procedures for quality, Member satisfaction, and grievance resolution;	**All Medical Products**
	Facilitate the identification of Participating Providers by Members; and	**All Medical Products**

	Designated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Medical Products**
	Access to online and/or on demand medical and health-related consultations via secure telecommunications technologies, telephones and internet are permitted and may include MDLIVE, a CHLIC affiliate (see details on myCigna.com).	**All Medical Products**
BEHAVIORAL HEALTH		
	CHLIC has contracted with an affiliate (details available upon request) to provide or arrange for the provision of managed in-network behavioral health services, the affiliate is a Participating Provider, and is reimbursed primarily on a monthly fixed fee basis This fixed fee for behavioral health services will be paid as claims and will appear in Employer's monthly reporting and on financial documents. Such payments will be at the relevant monthly rates then in effect. The monthly rates paid to the affiliate vary depending on geographic location of Members and on benefit design, and may be subject to change. The rates will be made available upon request. The fixed fee also includes applicable lifestyle management programs . Behavioral claims from a client specific network are not included in the behavioral monthly fixed fee and will be paid from the Bank Account. In some states, payment for behavioral health services must be paid on a fee-for-service basis. In these states, fee-for-service payments for behavioral health services and the behavioral health administrative fee (including the applicable lifestyle management programs) will be paid from the Bank Account as claims and will appear in Employer's monthly reporting.	**These services are included in the following products:** **HRA OAP,** **OAPIN** **and OAP Products**
CIGNA STAFF MODEL HEALTHPLAN SERVICES		
	The Cigna HealthCare of Arizona, Inc. staff model ("**Cigna Medical Group**" or "**CMG**") is a multispecialty participating provider group located in metropolitan Phoenix, Arizona. CMG's integrated care delivery model and population health management team work together to facilitate the way in which patients and doctors communicate and interact in order to increase patient satisfaction and improve health outcomes. Plan Participants may at some time receive treatment from a CMG facility or provider even if they do not reside in Arizona (as when traveling). Plan Participants utilizing Cigna participating provider networks in Arizona may access certain specialty and/or ancillary services (such as imaging and urgent care services) through the CMG system. For covered services provided to Participants, CMG is paid at the rates in effect at the time of service (as may be revised from time to time). Representative rates for routinely performed services are attached to the Schedule of Financial Charges herein. A complete copy of the rates is	**All Medical Products**

	available on request under a mutually agreed nondisclosure agreement ("**NDA**"). If the Plan requires or allows Participants to select a primary care provider ("**PCP**"), Phoenix area Participants who do not select a PCP during open enrollment may be assigned to or otherwise encouraged to consider a CMG PCP. CMG has established collaborative referral relationships with specialty and ancillary providers in Cigna's participating provider networks, which includes affiliated entities. CMG may also receive applicable performance-based incentive payments for its participation in programs designed to improve quality, patient safety and affordability. The incentive payments that CMG may receive will be determined using the same performance measures and reward formula as used in determining the incentive payments made to similarly situated non-Cigna affiliated provider entities. The amount of the incentive payments made to CMG and attributable to the plan will be provided upon request.	

CIGNA HEALTHCARE OF ARIZONA - CIGNA MEDICAL GROUP (CMG)
REPRESENTATIVE RATES FOR ROUTINELY PERFORMED MEDICAL SERVICES

EFFECTIVE JANUARY 1, 2020
(Applicable to Open Access Plus Products)

Department	CPT Code*	Description	Rate
All Departments	99213	OFFICE VISIT,EST EXP PROB FOC	$73.81
Adult Medicine	99396	WELL EXAM, EST, 40-64 YEARS	$126.72
Pediatrics	99392	WELL EXAM, EST, 1-4 YEARS	$106.46
Ophthalmology	66984	REMOVE CATARACT, INSERT LENS-Professional Fee only, at a facility	$641.43
Podiatry	11721	DEBRIDEMENT NAIL SIX OR MORE	$45.51
Radiology	71046	CHEST X-RAY, PA & LAT	$31.28
Radiology	77067 & 77063	SCREENING MAMMOGRAPHY DIGITAL	$189.64
General Surgery	47562	LAPAROSCOPY;CHOLECYSTECTOMY-Professional Fee only, at a facility	$666.13
Optometry	92014	EYE EXAM & TREATMENT	$126.12
ASC (Ambulatory surgical center) / Endoscopy Suite	Grouper 2		$469.00
ASC Endoscopy Suite	Grouper 8		$1,104.00

** Medicare does not assign (or may not yet have assigned) relative value units (RVUs) for certain service codes. Codes not valued by Medicare are referred to as "gap codes." For example, Medicare does not assign values for wellness service codes (99381-99397). CMG refers to The Essential RBRVS (Annual) guide to obtain relative values for such gap codes for billing purposes. Typically, Cigna pays CMG for gap codes not valued by Medicare either at the discounted fee schedule referenced above or, for new codes not yet valued by Medicare, at the same rate it pays its other participating providers.*

The Urgent Care case rate excluding radiology and laboratory services is $135.

Exhibit E – Conditional Claim/Subrogation Recovery Services

I. **Plans Without CHLIC Stop Loss Coverage**

If Employer has not purchased individual or aggregate stop loss coverage from CHLIC or an affiliate with respect to its self-funded employee welfare benefit plan:

(A) All conditional claim payment and/or subrogation recoveries under the Plan will be handled by CHLIC unless CHLIC is otherwise notified by the Employer.

(B) CHLIC and its subcontractors acting as Employer's recovery shall have the discretionary authority:

i. To reduce recovery amounts by as much as fifty percent (50%) of the total amount of benefits paid on Employer's behalf, and to enter into binding settlement agreements for such amounts. Any modification to this percentage shall be communicated by Employer to CHLIC and will be effective upon Employer's next renewal date, unless otherwise agreed to by CHLIC.

ii. In the event a settlement offer represents a reduction greater than the percentage identified above, CHLIC and its subcontractors shall seek settlement advice from the Employer.

iii. All amounts reimbursed to the Bank Account shall be refunded at the gross amount. CHLIC's and it subcontractors' subrogation administration fee on cases where CHLIC and its subcontractors' have retained counsel and in cases where no counsel has been retained by CHLIC and its subcontractors are both reflected in the Schedule of Financial Charges.

(C) Except where agreed to by CHLIC and Employer, CHLIC and its subcontractors shall have no duty or obligation to represent Employer in any litigation or court proceeding involving any matter which is the subject of the Agreement, but shall make available to Employer and/or Employer's counsel such information relevant to such action or proceeding as CHLIC and its subcontractors may have as a result of its handling of any matter under the Agreement.

(D) In the event Employer purchases individual or aggregate stop loss coverage from CHLIC or an affiliate with respect to its self-funded employee welfare benefit plan at any time during the life of the Agreement, the provisions of paragraph II., below, shall control.

II. **Plans with CHLIC Stop Loss Coverage**

If Employer has purchased individual or aggregate stop loss coverage from CHLIC or an affiliate with respect to its self-funded employee welfare benefit plan:

A. CHLIC and its subcontractors shall have the right and responsibility to manage all conditional claim payment and/or subrogation recoveries under the Plan. CHLIC and its subcontractors shall reimburse to the Plan the recovery minus relevant individual and aggregate stop loss payments made by CHLIC.

B. All amounts reimbursed to the Bank Account shall be refunded at the gross amount. CHLIC's and its subcontractors' subrogation administration fee on cases where CHLIC and its subcontractors' have retained counsel and in cases where no counsel has been retained by CHLIC and its subcontractors, are both reflected in the Schedule of Financial Charges.

C. CHLIC and its subcontractors shall have no duty or obligation to represent Employer in any litigation or court proceeding involving any matter which is the subject of the Agreement but shall make available to Employer and/or Employer's counsel such information relevant to such action or proceeding as CHLIC and its subcontractors may have as a result of its handling of any matter under the Agreement. Notwithstanding the foregoing, CHLIC and its subcontractors reserve to itself the right to retain counsel to represent CHLIC's own interests in any subrogation and/or conditional claim recovery action under the Plan.

Administrative Services Only (“ASO”) Agreement

By and Between

City of Fort Lauderdale
“Employer” or “City”

And

Cigna Health and Life Insurance Company
“CHLIC” or “Contractor”

Effective Date: January 1, 2017

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THIS AGREEMENT, effective January 1, 2017 (the "**Effective Date**") is by and between City of Fort Lauderdale ("**Employer**" or **"City"**) and Cigna Health and Life Insurance Company ("**CHLIC" or "Contractor"**).

RECITALS:

WHEREAS, Employer, as Plan sponsor, has adopted the benefit described in Exhibit A, as may be amended, ("**Plan**") for certain of its employees/members and their eligible dependents (collectively "**Members**"); and

WHEREAS, Employer, has requested CHLIC to furnish, certain administration services in connection with the Plan 3335139.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, it is hereby agreed as follows:

Definitions

Agreement – this entire document including the Schedule of Financial Charges and all Exhibits and Addenda.

Applicable Law – means the State of Florida and any other state laws applicable to payment of claims to participating providers in such other states, and federal laws and regulations that apply. Applicable Law includes but is not limited to the Health Insurance Portability and Accountability Act of 1996, as amended and the rules and regulations thereunder ("**HIPAA**"), the Foreign Corrupt Practices Act ("**FCPA**") and any other anti-bribery or anti-corruption laws in the countries where the Parties conduct business.

Bank Account – a benefit plan account with a bank designated by CHLIC; established and maintained by Employer in its name.

ERISA – the Employee Retirement Income Security Act of 1974, as amended and related regulations.

Extra-Contractual Benefits – Payments which Employer has instructed CHLIC to make for health care services and/or products that CHLIC has determined are not covered under the Plan.

Member – a person eligible for and enrolled in the Plan as an employee or dependent.

Participant/Participating Members – Member(s) who is (are) participating in a specific program and/or product available to Members under the Plan.

Participating Providers – providers of health care services and/or products, who/which contract directly or indirectly with CHLIC to provide services and/or products to Members.

Plan Benefits – Amounts payable for covered health care services and products under the terms of the Plan.

Party/Parties – refers to Employer and CHLIC, each a "Party" and collectively, the "Parties".

Plan Year – the twelve (12) month period, beginning on the Effective Date and, thereafter, each subsequent twelve (12) month period.

Run-Out Claims – claims for Plan Benefits relating to health care services and products that are incurred prior to termination of this Agreement, but that are submitted to CHLIC or are pending at or after the termination of this agreement.

Subscriber - the Member whose employment or participation is the basis for eligibility under the Plan.

Section 1. Term and Termination of Agreement

This Agreement is effective on the Effective Date and shall remain in effect until the earliest of the following dates:

i. The date which is at least thirty (30) days from the date that either Employer or CHLIC provides written notice to the other of termination of this Agreement;

ii. The effective date of any Applicable Law or governmental action which prohibits performance of the activities required by this Agreement;

iii. Three (3) business days after CHLIC notifies Employer of its election to terminate, which shall be triggered by the Employer failing to fund the Bank Account as required by this Agreement pursuant to Section 3.a.i. contained in the first sentence of Section 3.a or fifteen (15) business days after CHLIC notifies Employer of its election to terminate, which shall be triggered by the Employer failing to fund the Bank Account as required by this Agreement pursuant to Section 4.a.

iv. Any other date mutually agreed upon by Employer and CHLIC.

Section 2. Claim Administration and Additional Services

a. While this Agreement is in effect, CHLIC shall, consistent with, the claim administration policies and procedures then applicable to its own health care insurance business (i) receive and review claims for Plan Benefits; (ii) determine the Plan Benefits, if any, payable for such claims; (iii) disburse payments of Plan Benefits to claimants; and (iv) provide in the manner and within the time limits required by Applicable Law, notification to claimants of (a) the coverage determination or (b) any anticipated delay in making a coverage determination beyond the time required by Applicable Law.

b. Following (i) termination of this Agreement, except pursuant to Section 1 (iii); (ii) termination of a Plan benefit option or (iii) termination of eligible Members, if the required fees have been paid in full, if any, CHLIC shall process Run-Out Claims for the applicable Run-Out Period (Refer to Schedule of Financial Charges for applicable fees and Run-Out Period). At the termination of any applicable Run-Out Period, CHLIC shall cease processing Run-Out Claims and, subject to the requirements of Section 6.b, make all relevant records in its possession relating to such claims reasonably available to Employer or Employer's designee. CHLIC is not required to provide information that is confidential pursuant to Florida law to Employer or any other party.

c. Employer hereby delegates to CHLIC the authority and responsibility to (i) determine eligibility and enrollment for coverage under the Plan according to the information provided by the Employer, (ii) make factual determinations and to interpret the provisions of the Plan to make coverage determinations on claims for Plan Benefits, (iii) conduct a full and fair review of each claim which has been denied, (iv) decide level one mandatory appeals for claims and (v) notify the Member or the Member's authorized representative of its decision in accordance with applicable state and federal regulations. CHLIC shall prepare and deliver Member draft summary plan description materials to Employer that are compliant with applicable state and federal laws and regulations. Employer will ensure that all summary plan description materials provided to Members reflect this delegation.

d. In addition to the basic claim administrative duties described above, CHLIC shall also perform the Plan-related administrative duties agreed upon by the Parties and specified in Exhibit B. All services identified in this Agreement shall be provided by CHLIC on an exclusive basis unless otherwise agreed to in writing by CHLIC.

Section 3. Funding and Payment of Claims

a. Employer shall establish a Bank Account**,** and maintain in the Bank Account an amount sufficient at all times to fund claims for (i) Plan Benefits based upon checks cleared through the Bank Account; and (ii) those charges and fees identified in the Schedule of Financial Charges as payable through the Bank Account (collectively "**Bank Account Payments**"); or any similar benefit- or Plan-related charge or assessment however denominated, which may be imposed on the Employer by any governmental authority. Bank Account Payments may include without limitation: (i) capitated (i.e. fixed per Member) and pay-for-performance incentive payments to Participating Providers; (ii) amounts owed to CHLIC; and (iii) amounts paid to CHLIC's affiliates and/or subcontractors for,

among other things, network access or in- and out-of network health care services/products provided to Members. CHLIC may credit the Bank Account with payments due Employer under its or an affiliate's stop loss policy.

b. CHLIC, as agent for the Employer, shall make Bank Account Payments from the Bank Account, in the amount that is proper under the Plan and/or under this Agreement.

c. In the event that sufficient funds are not available in the Bank Account to pay all Bank Account Payments when due, CHLIC shall notify Employer of the need for additional funding and if these are not received within three business days CHLIC may cease to process claims for Plan Benefits including Run-Out Claims until such time as sufficient funds are available in the Bank Account to pay all Bank Account Payments when due.

d. CHLIC will promptly adjust any underpayment of Plan Benefits by drawing additional funds due the claimant from the Bank Account. In the event CHLIC overpays a claim for Plan Benefits or pays Plan Benefits to the wrong party, it shall take all reasonable steps to recover the overpayments. CHLIC shall not be required to initiate court, mediation, arbitration or other administrative proceedings to recover any overpayment. CHLIC shall not be liable to the Employer for unrecovered claim overpayments that are the result of mistakes of judgment or other actions that are reasonable and taken in good faith. However, CHLIC shall reimburse the Plan for unrecovered overpayments resulting from its failure, in the aggregate, to perform its duties with the degree of skill and judgment possessed by other third party administrators experienced in furnishing claim administration services to plans of similar size and characteristics as the Plan.

e. Following termination of this Agreement, Employer shall remain liable for payment of all due Bank Account Payments and for all reimbursements due Members under the Plan. Except as otherwise provided in subsection 3.d., Employer shall promptly reimburse CHLIC for any Bank Account Payments paid by CHLIC with its own funds and no such payment by CHLIC shall be construed as an assumption of any of Employer's liability.

This Section 3 shall survive termination of this Agreement.

Section 4. Charges

a. Charges. CHLIC shall provide to Employer a monthly statement of all administrative (ASO) charges Employer is obligated to pay under this Agreement. ASO payments of all billed charges shall be due on the first day of the month, as indicated on the monthly statement. Payments received after the last day of the month in which they are due, shall be subject to interest charges, from the due date at a rate calculated in accordance with the Florida Local Government Prompt Payment Act. For purposes of calculating interest charges, payments received will be applied first to the oldest outstanding amount due.

b. Changes – Additions and Terminations. If a Subscriber's effective date is on or before the fifteenth (15th) day of the month, full charges applicable to that Subscriber shall be due for that Subscriber for that month. If coverage does not start or ceases on or before the fifteenth (15th) day of the month for a Subscriber, no charges shall be due for that Subscriber for that month.

c. Retroactive Changes and Terminations. Employer shall remain responsible for all applicable charges and Bank Account Payments incurred or charged through the date Employer provides to CHLIC Employer's notice of a retroactive change or termination of Membership. However, if the change or termination would result in a reduction in charges, CHLIC shall credit to Employer the reduction in charges charged for the shorter of (a) the sixty (60) day period preceding the date CHLIC processes the notice, or (b) the period from the date of the change or termination to the date CHLIC processes the notice. This provision shall survive termination of this Agreement.

This Section 4 shall survive termination of this Agreement.

Section 5. Enrollment and Determination of Eligibility

a. Eligibility Determinations and Information. Employer is responsible for administering Plan enrollment. In determining any person's right to benefits under the Plan, CHLIC shall rely upon enrollment and eligibility information provided by the Employer. Such information shall identify the effective date of eligibility and the

termination date of eligibility and shall be provided promptly to CHLIC in a form and with such other information as reasonably may be required by CHLIC for the proper administration of the Plan.

b. Release of Liability. Notwithstanding any inconsistent provision of this Agreement to the contrary, if Employer, fails to provide CHLIC with accurate enrollment and eligibility information, benefit design requirements, or other agreed-upon information in accordance with this Agreement, CHLIC shall have no liability under this Agreement for any act or omission by CHLIC, or its employees, affiliates, subcontractors, agents or representatives, directly caused by such failure.

c. Reconciliation of Eligibility and Information and Default Terminations. CHLIC will periodically (at least monthly) share potential discrepancies in eligibility information with Employer. CHLIC will review and reconcile any discrepancies within five (5) days of CHLIC's receipt. CHLIC will terminate coverage for any Member not listed as eligible in Employer's submitted eligibility information.

Section 6. Claim Audit and Confidentiality

a. **Claim Audit**. Employer or its designee, may, in accordance with the following requirements and at no additional charge while this Agreement is in effect, audit CHLIC's payment of Plan Benefits:

i. Employer, or its designee, shall provide CHLIC forty-five (45) days advance written request for audit from the latter of (i) receipt by CHLIC of the audit scope letter or (ii) the fully executed Claim Audit Agreement attached hereto as Exhibit C. Employer will designate with CHLIC's consent, such consent not to be unreasonably withheld, an independent, third party auditor to conduct the audit (the "**Auditor**). In addition, Employer and CHLIC will agree upon the date for the audit during regular business hours at CHLIC's office(s). Employer shall be responsible for its Auditor's costs. Except as otherwise agreed to by the parties in writing prior to the commencement of the audit, the audit shall be conducted in accordance with the terms of CHLIC's Claim Audit Agreement attached hereto as Exhibit C, which is hereby agreed to by Employer and which shall be signed by the Auditor prior to the start of the audit.

ii. If Employer has at least four thousand (4,000) Members, Employer may conduct one such audit every Plan Year (but not within six (6) months of a prior audit); otherwise, Employer may conduct one such audit every two (2) Plan Years (but not within eighteen (18) months of a prior audit).

iii. Auditor will review payment documents relating to a random, statistically valid sample of two-hundred twenty-five (225) claims paid during the two prior Plan years and not previously audited (the "**Audit**") subject to any contrary terms in Participating Provider agreements. With respect to the Audit, the scope may include types of claims prone to overpayments provided the types of claims prone to underpayments are equally included and will exclude electronic analysis. Any claim adjustments will be based upon the actual claims reviewed and not upon statistical projections or extrapolations.

iv. Should Employer or its designee need access to information or records that are held by a subcontractor of CHLIC, CHLIC shall cooperate with Employer or its designee to obtain such information or records in a timely manner.

b. **Confidentiality**

i. Subject to the requirements of Applicable Law, the terms of this Agreement and, a signed Business Associate Agreement between Employer and designee, CHLIC shall release copies of confidential claims and Plan Benefit payment information in CHLIC's claims system ("**Confidential Information**") and may release copies of proprietary information relating to the Plan in CHLIC's claims system ("**Proprietary Information**") to the Employer and/or its designees. Except as otherwise provided by Applicable Law, Employer agrees that Employer will keep Confidential Information and Proprietary Information confidential and will use Confidential Information and Proprietary Information solely for the purpose of administering the Plan or as otherwise required by law. If Employer directs CHLIC to release any Confidential Information or Proprietary Information, CHLIC is not responsible to the Employer for the

consequences of any use, misuse, or disclosure of Confidential Information provided by CHLIC pursuant to this paragraph b.

ii. CHLIC will maintain the confidentiality of all Protected Health Information in its possession in accordance with the Business Associate Agreement between Employer and CHLIC pursuant to the Health Insurance Portability and Accountability Act and any Applicable Laws.

iii. This Agreement and all documents generated pursuant to this Agreement, except to the extent they are exempt from disclosure or confidential pursuant to Florida law, are public records that are open to inspection and copying pursuant to Florida law.

iv. **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 (954-828-5002, PRRCONTRACT@FORTLAUDERDALE.GOV, CITY CLERK'S OFFICE, 100 NORTH ANDREWS AVENUE, FORT LAUDERDALE, FLORIDA, 33301).**

Notwithstanding any provision contained in this Agreement to the contrary, Contractor shall:

1. Keep and maintain public records that ordinarily and necessarily would be 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 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 Chapter 119, Florida Statutes (2016), as may be amended or revised, 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 this 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 this 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 this 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.

c. Upon termination of this Agreement and subject to the provisions of Section 6.b above, CHLIC shall make information available to any subsequent administrator to the extent administratively feasible. The Parties will agree upon the charge to be paid by Employer at such time of transition.

The obligations set forth in this section, shall survive termination of the Agreement.

Section 7. Plan Benefit Liability

a. Employer Liability for Plan Benefits. Employer is responsible for all Plan Benefits including any Plan Benefits paid as a result of any legal action. CHLIC shall reasonably cooperate with Employer, in its defense of such actions.

If CHLIC pays a claim for Extra-Contractual Benefits at Employer's direction, Employer is responsible for funding the payment.

b. Employer Liability for Plan-Related Expenses. Employer shall reimburse CHLIC for any amounts CHLIC may be required to pay (i) as state premium tax or any similar Plan-related tax, charge, surcharge or assessment, or (ii) under any unclaimed or abandoned property law, or escheat law, with respect to Plan Benefits and any penalties and/or interest thereon.

c. Standard of Care/Indemnity: In performing its obligations under this Agreement, CHLIC shall use reasonable diligence and that degree of skill and judgment possessed by one experienced in furnishing claim administration services to plans of similar size and characteristics as the Plan. CHLIC shall not be liable to the Employer for mistakes of judgment or other actions taken in good faith (including benefits erroneously overpaid) but shall be liable to and indemnify the Employer for any non-benefit loss, cost or expense (including reasonable attorneys' fees and court costs) for which Employer may become liable in consequence of any acts or omissions of CHLIC which, in the aggregate, constitute a failure on the part of CHLIC to perform its claim administration obligations under this Agreement in accordance with the standard set forth above.

The reimbursement obligations set forth in this Section 7 shall survive termination of this Agreement.

Section 8. Modification of Plan and Charges

a. The Medical Administration Charges in effect from January 1, 2017 through and including December 31, 2019, shall be as set forth in the Schedule of Financial Charges attached hereto and CHLIC may revise such Medical Administration Charges only (i) upon any modification or amendment of the benefits under the Plan, (ii) upon any variation of fifteen percent (15%) or more in the number of Members used by CHLIC to calculate its charges under the Agreement, and/or (iii) upon any change in law or regulation that materially impacts CHLIC liabilities and/or responsibilities under this Agreement.

b. Employer shall provide CHLIC written notice of any modification or amendment to the Plan sufficiently in advance of any such change as to allow CHLIC to implement the modification or amendment. Employer and CHLIC shall agree upon the manner and timing of the implementation subject to CHLIC's system and operational capabilities.

c. Employer is solely responsible for communicating any Plan modification or amendment to Members or individuals considering enrolling in the Plan.

Section 9. Modification of Agreement

Vacant

Section 10. Laws Governing Agreement

a. This Agreement shall be governed by and construed in accordance with the laws of the State of Florida without regard to conflict of law rules, and both Parties consent to the venue and jurisdiction of its courts. Venue for any lawsuit by one party against the other party or otherwise arising out of this Agreement, and for any other legal proceeding, shall be in Broward County, Florida, or in the event of federal jurisdiction, in the Southern District of Florida, Fort Lauderdale Division.

b. The Parties shall perform their obligations under this Agreement in conformance with all Applicable Laws and regulatory requirements.

Section 11. Information in CHLIC Processing Systems

CHLIC may retain and use all Plan-related claim and Plan Benefit payment information recorded for or otherwise integrated into CHLIC's business records including claim processing systems during the ordinary course of business

(provided, however, that claim or payment information will be available to Employer pursuant to Section 6.b.). CHLIC will retain claim and payment information as required by Applicable Law and the Florida public records law and related public records retention schedules.

Section 12. Resolution of Disputes

Any dispute between the Parties arising from or relating to the performance or interpretation of this Agreement ("**Controversy**") may be addressed pursuant to the following dispute resolution procedures:

a. Any Controversy shall first be referred to an executive level employee of each Party who shall meet and confer with his/her counterpart to attempt to resolve the dispute ("**Executive Review**") as follows: The disputing Party shall give the other Party written notice of the Controversy and request Executive Review. Within twenty (20) days of such written request, the receiving Party shall respond to the other in writing. The notice and the response shall each include a summary of and support for the Party's position. Within thirty (30) days of the request for Executive Review, an employee of each Party shall meet and attempt to resolve the dispute. Resolution of disputes is subject to Section 2-151, Code of Ordinances of the City of Fort Lauderdale, Florida, as may be amended or revised, which provides, in pertinent part, as follows:

    Claims or demands, including workers' compensation claims, brought against or on behalf of the city may be settled, adjusted and otherwise compromised without the approval of the city commission upon the following terms and conditions and when in the judgment of the risk manager, the director of finance, city manager and the city attorney or their designees such would be in the best interests of the city to do so:

    (1) For all claims or demands which do not exceed one thousand dollars ($1,000.00), such claims or demands may be settled, adjusted or otherwise compromised by the risk manager.

    (2) For all claims or demands which exceed one thousand dollars ($1,000.00) but do not exceed three thousand dollars ($3,000.00), such claims or demands may be settled, adjusted or otherwise compromised by the joint approval of the risk manager and the director of finance.

    (3) For all claims and demands which exceed three thousand dollars ($3,000.00), but do not exceed twenty thousand dollars ($20,000.00), such claims or demands may be settled by joint approval of the risk manager, director of finance, the city manager and the city attorney.

    (4) …

    (5) For all claims or demands which exceed twenty thousand dollars ($20,000.00), such claims shall be submitted for settlement, adjustment or compromise to the city commission for approval.

b. If the Controversy has not been resolved within thirty-five (35) calendar days of the request of Executive Review under Section 12.a, above, the Parties agree to mediate the Controversy in accordance with the Florida Supreme Court Mediation Rules ("**Mediation**"). The mediation shall be conducted in Broward County, Florida. Each Party shall assume its own costs and attorneys' fees. The mediator's compensation and expenses and any administrative fees or costs associated with the mediation proceeding shall be borne equally by the Parties.

Section 13. Third Party Beneficiaries

This Agreement is solely for the benefit of Employer and CHLIC. It shall not be construed to create any legal relationship between CHLIC and any other party.

Section 14. Waivers

No course of dealing or failure of any Party to strictly enforce any term, right or condition of this Agreement shall be construed as a waiver of such term, right or condition. Waiver by either Party of any default shall not be deemed a waiver of any other default.

Section 15. Headings

Article, section, or paragraph headings contained in this Agreement are for reference purposes only and shall not affect the meaning or interpretation of this Agreement.

Section 16. Severability

If any provision or any part of a provision of this Agreement is held invalid or unenforceable by a court of competent jurisdiction, such invalidity or unenforceability shall not invalidate or render unenforceable any other portion of this Agreement.

Section 17. Force Majeure

Neither Party shall be liable for any failure to meet any of the obligations required under this Agreement where such failure to perform is due to any contingency beyond the reasonable control of such Party, its employees, officers, or directors. Such contingencies include, but are not limited to, acts of God, fires, wars, accidents, labor disputes or, governmental laws, ordinances, rules or regulations. Notwithstanding the foregoing, this section shall not in any way alter or release the Employer from its obligations to pay for Plan benefits.

Section 18. Assignment and Subcontracting

Neither Party may assign any right, interest, or obligation hereunder without the express written consent of the other Party; provided, however that CHLIC may subcontract specific obligations under the Agreement to an affiliate owned and controlled by CHLIC provided that CHLIC shall not be relieved of its obligations under the Agreement when doing so.

Section 19. Notices

Except as otherwise provided, all notices or other communications hereunder shall be in writing and shall be deemed to have been duly made when (a) delivered in person, (b) delivered to an agent, such as an overnight or similar delivery service, (c) delivered electronically, or (d) deposited in the United States mail, postage prepaid, and addressed as follows:

To CHLIC:
Cigna Health and Life Insurance Company
401 Chestnut Street
Chattanooga, TN 37402
Attention: Melinda Lefebvre, Financial Analysis Manager

To Employer:
City of Fort Lauderdale
100 North Andrews Avenue
Fort Lauderdale, FL 33301
Attention: Guy Hine, Risk Manager

The address to which notices or communications may be given by any Party may be changed by written notice given by one Party to the other pursuant to this Section.

Section 20. Identifying Information and Internet Usage

Except, as necessary in the performance of their duties under this Agreement, and except as otherwise provided by the Florida public records law, neither Party may use the other's name, logo, service marks, trademarks or other identifying information or to establish a link to the other's World Wide Web site without its prior written approval.

Schedule of Financial Charges

Certain fees and charges identified in this Schedule of Financial Charges will be billed to Employer monthly in accordance with CHLIC's then standard billing practices. However, CHLIC is authorized to pay all fees and charges from the Bank Account unless otherwise specified in this Agreement.

	MEDICAL ADMINISTRATION CHARGES	
Product	**Description**	**Charge**
Medical	• Open Access Plus (OAP) with PHS Plus Medical Management	**$12.65/employee/month**
Medical	• HRA Open Access Plus (OAP) with PHS Plus Medical Management	**$12.65/employee/month**
Medical	• Open Access Plus In-Network (OAPIN) with PHS Plus Medical Management (All Plans)	**$12.65/employee/month**
MEDICAL NETWORK ACCESS FEE, UTILIZATION MANAGEMENT FEE AND OPTIONAL PROGRAM FEE		
Product	**Description**	**Charge**
Medical	• OAP Access Fee	**$20.95/employee/month Includes $10.50 Base Access Fee, $5.25 Your Health First, $3.20 Health Advisor, $2.00 PHS+**
Medical	• HRA OAP Access Fee	**$17.75/employee/month Includes $10.50 Base Access Fee, $5.25 Your Health First, $0.00 Health Advisor, $2.00 PHS+**
Medical	• OAPIN Access Fee (All Plans)	**$20.95/employee/month Includes $10.50 Base Access Fee, $5.25 Your Health First, $3.20 Health Advisor, $2.00 PHS+**
CIGNA CHOICE FUND AND OTHER CONSUMER DIRECTED ACCOUNT ADMINISTRATION SERVICES AND CHARGES		
	Product	**Charge**

	• Cigna Choice Fund Health Reimbursement Account (HRA) Administration	**$4.50/employee/month**
Health Advisor – A	The Health Advisor program focuses on engaging targeted Members related to a variety of wellness and prevention topics, and is designed to facilitate healthy behaviors and promote achievement of health-related goals. The program includes the following components: • Health and wellness coaching on high blood pressure, high cholesterol, healthy eating, physical activity and pre-diabetes using multiple coaching sessions, behavior modification techniques and other motivational interviewing and coaching styles to encourage behavior change that helps Participants reach established goals. • Education and referral coaching on program topics with referral to appropriate internal and external resources available • Access to educational materials and web based Member tools and resources • Identification of gaps in care and outreach to Members to provide coaching for those identified with gaps for high cholesterol, high blood pressure • Support of Participants identified through predictive modeling with certain preference sensitive care conditions by supplying impartial evidence based medical information, to empower Participants' to understand the potential benefits/ disadvantages of a specific course of action and make more informed care decisions. • Answering health and medical related questions • Counseling Participants on prevention and the benefits of compliance with prescribed medications and treatments	**For HRA OAP Only there is no additional charge for this program Included in Medical Access Fee**
AMOUNTS OWED TO CHLIC		
Amounts paid by CHLIC with its own funds on behalf of Employer or the Plan with respect to charges for which Employer or the Plan is obligated to pay under this Agreement including Plan Benefits, Bank Account Payments (including fix per person payments and pay-for-performance payments to Participating Providers), governmental taxes or assessments.		
FEES FOR PROCESSING RUN-OUT CLAIMS		
OAP, HRA OAP, and OAPIN	Run-Out Period of twelve (12) months	**No Additional Cost**
CREDITS		
	CHLIC agrees to provide the City with either (i) a four (4) month fee credit when the City renews Medical and Pharmacy ASO Administration services with CHLIC or (ii) a six (6) month fee credit for the renewal of Medical and Pharmacy ASO Administration services and stop-loss coverage being retained by CHLIC.	
SUBROGATION		

	Subrogation/Conditional Claim Payment. Identification, investigation and recovery of claim payments involving other party liability or where another entity is responsible for payment (including by way of example but not by limitation automobile insurance, homeowner insurance, commercial property insurance, worker's compensation). (This service is only provided with respect to Medical coverage).	**5% of recovery plus litigation costs if counsel is retained and an appearance is filed on behalf of CHLIC or Employer in any litigation, or a lawsuit is filed on their behalf;** **29% of recovery if no counsel is retained and in all other instances, including cases where state law requires that employee benefit plans be named as party defendants or involuntary plaintiffs.**

CHLIC COST CONTAINMENT FEES
CHLIC, a Cigna company, administers the following programs to contain costs with respect to charges for health care service/supplies that are covered by the Plan. In administering these programs, CHLIC contracts with vendors to perform program related services. Specific vendor fees are available upon request. CHLIC's charge for administering these programs is the percentage (indicated below) of either (1) the "net savings" (i.e. the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings, less the applicable vendor fee which generally ranges from 7-11% of the program savings) or (2) the "gross savings" (i.e. the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings; CHLIC pays the applicable vendor fee) or (3) the "recovery" (i.e. the amount recovered) as applicable. For charges for covered services received from a non-Participating Provider (including emergency/urgent care services that are covered at the in-network benefit level), CHLIC may apply discounts available under agreements with third parties or through negotiation of the billed charges. These programs are identified below as the Network Savings Program, Supplemental Network & Medical Bill Review (pre-payment). CHLIC charges the percentage shown for administering these programs. Applying these discounts may result in higher payments than if the maximum reimbursable charge is applied. Whereas application of the maximum reimbursable charge may result in the patient being balance billed for the entire unreimbursed amount, applying these discounts avoids balance billing and substantially reduces the patient's out-of pocket cost. If no discount is available or negotiated, reimbursement will be based upon: (i) If charges are not subject to CHLIC's benefit enhancement policy – the plan's maximum reimbursable charge (in which case the patient may be balance billed by the provider if the provider's charge exceeds the plan's maximum reimbursable charge); or (ii) If charges are subject to CHLIC's benefit enhancement policy – depending upon the Employer's election: a. the amount of provider's billed charge not exceeding the greater of a CHLIC determined percentage of the Medicare allowable amount (the 80th percentile of the reasonable and customary charge if there is no Medicare allowable charge) or the amount required by state or federal, law (in the case of emergency room services) for charges subject to CHLIC's benefit enhancement policy (patient may be balance billed by the provider if the provider's charge exceeds such amount), or b. the provider's billed charge. This administration of charges for covered services from non-Participating Providers is consistent with the claim administration practices with respect to CHLIC's own health care insurance business where applicable.

MEDICAL COST CONTAINMENT		
1.	Network Savings Program	**29% of net savings**
2.	Supplemental Network	**29% of net savings**
3.	Medical Bill Review – (Pre-payment Cost Containment for Non-contracted claims):	
	Inpatient Hospital Bill Review	
	• Line Item Analysis	**Lesser of 5% of hospital bill or the savings achieved**

	• Professional Fee Negotiation	**29% of net savings**
	Outpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
	Physician/Professional Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
4.	Medical Bill Review – (Pre or Post-payment Cost Containment for Non-contracted and Contracted claims):	
	• Bill Audit	**29% of the savings/recovery achieved plus hospital fees or expenses passed through**
	Diagnosis Related Grouping (DRG) Validation/Audits and Recovery. An overpayment audit and recovery program in which CHLIC or its vendors review paid claim data to identify overpayments based on inaccurate DRG coding.	**29% of recovery plus any fees or expenses passed through by the hospital or regulatory agency**
	Inpatient Admission Retrospective Review	**29% of recovery**
	Medical Implant Device Audits	**29% of recovery**
5.	COB Vendor Recoveries [Exclusive of pharmacy programs where claims are adjudicated at time prescription is received.]	**29% of recovery**
6.	Secondary Vendor Recovery Program	**29% of recovery**
7.	Provider Credit Balance Recovery Program	**29% of recovery**

CARE MANAGEMENT/COST CONTAINMENT PROGRAM FEES		
	CHLIC arranges for third parties to provide care management services to: (i) contain the cost of specified health care services/items overall with respect to all plans insured and/or administered by CHLIC, and/or (ii) improve adherence to evidence based guidelines designed to promote patient safety and efficient patient care.	**Specific vendor fees and care management program services are available upon request.**
ELIGIBILITY OVERPAYMENT RECOVERY FEES		
	Eligibility Overpayment Recovery Vendor Services. Identification and recovery of funds in situations where the overpayment is due to the late receipt of Member termination information. (This service is only provided with respect to Medical coverage).	**29% of recovery**
EXTERNAL REVIEW AND CONSULTATIVE REVIEW FEES		
	When a Member elects an External Review (as that term is defined in ERISA) of a benefit determination by an independent third party, the cost of a specific third party review is dependent on the nature and complexity of the issue on appeal. In highly complex, non-routine cases or cases related to new technology or experimental-investigational treatment, as part of the internal appeal process a panel of reviewers may be necessary. Third party review charges will be commensurate with the number of reviewers (usually only one is used), as well as their level of expertise and time required to complete the review.	**$500-$4,000 Review**
STRATEGIC ALLIANCES		
	CHLIC contracts directly or indirectly with other managed care entities and third party network vendors for access to their provider networks and discounts. These third parties charge either a network access fee, which is included in CHLIC's monthly charges, or a percentage of the savings realized on a claim by claim basis as a result of the application of their discounts. Charges based on percentage of savings may be paid from the Bank Account. Additional details regarding specific charges will be provided upon request.	**All Medical Products**
OTHER VENDORS AND HEALTH CARE SERVICES PROVIDERS		
	Fixed per person per period and fee-for-service charges for various vendors and other providers/arrangers of health care services and/or supplies will be paid as claims for Plan Benefits. In addition, performance-based payments to Participating Providers will be charged to the Bank Account. Such payments will be at the payment rates then in effect, which may be amended from time to time. Additional details regarding charges and the identity of the vendor or provider of health care services will be made available upon request.	**All Products**

NOTICE REGARDING PAYMENTS FROM THIRD PARTIES		
	Unless indicated otherwise in the Schedule of Financial Charges, CHLIC retains all payments it may receive from manufacturers of pharmaceutical products covered under the Plan. Information on the amount of such payments with respect to the Plan will be provided upon request.	**All Pharmacy Products**
	From time to time, CHLIC, directly or through its affiliates, arranges with third party parties (e.g., service vendors, provider network managers) to provide various services (e.g., cost-containment initiatives) in connection with the Plan. CHLIC and its affiliates may receive payments from such third parties to help defray CHLIC's expenses associated with the implementation and/or ongoing administration of these arrangements. CHLIC may also receive compensation from third-party vendors that Employer may retain based upon a referral from CHLIC or that Members may utilize following an introduction facilitated by CHLIC or an affiliate.	**All Products**
	COMPLIANCE ASSISTANCE	
	CHLIC shall provide the following services to assist Employer in meeting its compliance obligations under section 2715 of the Public Health Service Act as added by the Patient Protection and Affordable Care Act and applicable regulations with respect to the provision of the Summary of Benefits and Coverage (“SBC), translation notice and glossary. Applicable to all medical plans including HRA and FSA which are considered "group health plans" subject to the SBC requirements.	
1.	Preparation of SBC, translation notice. CHLIC will not be responsible for any changes that Employer makes to the SBC.	**No charge**
2.	Provide SBC, translation notices prepared by CHLIC to Employer electronically as well as any updates or material modifications.	**No charge**
3.	Include in SBC a summary of benefits administered by carve-out vendor if Employer or carve-out vendor provides CHLIC with necessary carve-out benefit information at least twelve (12) weeks prior to the date the SBCs are to be delivered to Employer.	**$500 for each benefit option under the Plan for which carve-out vendor benefits are included in SBC**

ADDITIONAL SERVICES		
Service	**Description**	**Charge**
Behavioral Health	Behavioral Care Advocacy provides behavioral health services in which claims are funded on a fee-for service basis. It includes focused utilization review and case management for inpatient, in-network behavioral health services. This payment arrangement is with respect to the CA/NC Member population only.	**Included in Medical Access Fee**
Health Advisor – A	The Health Advisor program focuses on engaging targeted Members related to a variety of wellness and prevention topics, and is designed to facilitate healthy behaviors and promote achievement of health-related goals. The program includes the following components: • Health and wellness coaching on high blood pressure, high cholesterol, healthy eating, physical activity and pre-diabetes using multiple coaching sessions, behavior modification techniques and other motivational interviewing and coaching styles to encourage behavior change that helps Participants reach established goals • Education and referral coaching on program topics with referral to appropriate internal and external resources available • Access to educational materials and web based Member tools and resources • Identification of gaps in care and outreach to Members to provide coaching for those identified with gaps for high cholesterol, high blood pressure • Support of Participants identified through predictive modeling with certain preference sensitive care conditions by supplying impartial evidence based medical information, to empower Participants' to understand the potential benefits/ disadvantages of a specific course of action and make more informed care decisions • Answering health and medical related questions • Counseling Participants on prevention and the benefits of compliance with prescribed medications and treatments	**For OAP and OAPIN Only $3.20/employee/month Included in Medical Access Fee**
Incentive Tracking for Management Wellness Plan	The City has a Management Wellness plan that provides management employees with a $500 incentive based on completion of the defined activities. Cigna agrees to track incentives for the City, however the City will indemnify Cigna and hold it harmless from and against all contractual or extra contractual claims, amounts, liabilities, reasonable costs and/or expenses (including attorney's fees and court costs) which Cigna or the City may incur in connection with such tracking or in connection with any judicial, quasi-judicial or administrative proceedings relating thereto.	

Your Health First	A proactive health education and improvement program for Members with a chronic condition. The program involves services that span across the Member's health needs. Behavioral coaching principles and evidence based medicine guidelines are utilized to optimize self-management skills and foster sustained health improvements. The program targets a chronic population at high risk for near term and future high cost medical expenses. Members are identified as having a chronic condition through a variety of sources which may include: claims data, referrals, and self-identification. A variety of resources is provided to those with a chronic condition, including access to online tools, personalized support, and targeted materials. The program includes the following components for those with a chronic condition: • Chronic condition-specific coaching • Pre- and post-discharge calls • Lifestyle management coaching: stress, weight management and tobacco cessation • Treatment decision support and coaching In order to continuously assess the effectiveness of the program and/or test new ideas to further engage Members around their health, a small sample of Members may be placed in a comparison group which for a defined period of time receives alternative services or is suppressed from receiving proactive outreach, such as engagement letters and/or calls. This could affect a few Members targeted for outreach during this limited time period.	**For OAP, HRA OAP, and OAPIN Products: $5.25/employee/month Included in Medical Access Fee**
Medical Conversion Privilege	Converting Employee Does Not Reside in NY, CO, FL, TX∗ Comprehensive/Major Medical Plans Base Plans (Limited Hospital/Surgical)	**$20,000/conversion policy**
	Converting Employee Resides in NY: Comprehensive/Major Medical Plans Base Plans (Limited Hospital/Surgical)	**$20,000/conversion policy**
	Converting Employee Resides in CO: Comprehensive/Major Medical Plans Base Plans (Limited Hospital/Surgical)	**$20,000/conversion policy**
	Converting Employee Resides in FL: Comprehensive, Base Plan/Major Medical and PPO Plans	**$20,000/conversion policy**

∗ CHLIC does not provide Medical Conversion coverage to Texas residents. Medical Conversion coverage for Texas residents is provided by the Texas Health Insurance Risk Pool.

Internet-Based Enrollment and Eligibility Management System	CHLIC, either directly or through its affiliate, Cigna Guided Solutions, will grant to Employer and Participants a nontransferable limited license to access Benefits Insight, CHLIC's Internet-Based Enrollment and Eligibility Management System for online enrollment and selection of benefits. Products and services are outlined in the Statement of Services provided to the Employer by Cigna Guided Solutions. More specific information about the products, services, charges, grant of license and applicable restrictions are available upon request.	**Included in Medical Administration Charge**
Employee Assistance Program Full Service STC 1-10	CHLIC provides the Employee Assistance Program Services ("EAP") for EAP Participants through its affiliate experienced in establishing and administering an EAP, Cigna Behavioral Health, Inc. ("Cigna Behavioral"). The clinical component of the EAP provided to EAP Participants who reside in California and/or Nevada is covered under the short-term counseling policy(ies) issued to Employer by CHLIC and not by the terms of this Contract. All other EAP services for such EAP Participants who do not reside in California or Nevada are covered by the following terms. **EAP Participant:** Any person who is eligible to receive Cigna Behavioral EAP Services provided pursuant to this Contract, including Employer's employees, their dependents and members of employees' households. Employer Service Hours - 2 hours per 1000 employees or 5 actual hours per contract year; 10 service hours annually per 1,000 employees for orientations, seminars or training, onsite crisis intervention	**$2.24 PEPM**

Client Fund		
Wellness Fund	For clinical/wellness/behavioral programs offered by CHLIC that are purchased, CHLIC will establish a Wellness Fund in the amount of $87,000.00. This fund will be used to defray the cost of CHLIC designated and arranged health and wellness improvement programs (e.g. biometric screenings, flu shots) for employees of Employer and to reward participation in these programs. The Wellness Fund is a one-time credit , however, unused funds can be rolled over each year. CHLIC must pre-approve use of the Wellness Fund. The Wellness Fund shall be extinguished upon termination of this Agreement and any fund amount not used prior to termination of this Agreement shall only be available to Employer for the purpose of funding the cost of those reimbursable services provided prior to such termination.	

Exhibit A - Plan Booklet

A "Plan Booklet" that describes the Plan Benefits and Members' rights and responsibilities under the Plan will be provided by Employer to CHLIC for its use in administering the Plan including denials and appeals of denials of claims for Plan Benefits. If Employer has not provided CHLIC with a copy of its finalized Plan Booklet by the time this Agreement is effective, CHLIC will administer the Plan in accordance with the Plan Benefits described in the Plan Booklet draft provided by CHLIC to Employer and Section 2 of this Agreement. CHLIC will continue to administer the Plan in this manner until CHLIC receives the finalized Plan Booklet and follows CHLIC's preparation and review process. After that time CHLIC will administer the Plan in accordance with Plan Benefits described in the finalized Plan Booklet and Section 2 of this Agreement.

Exhibit B – Services

BANKING AND ADMINISTRATION		
Products <u>excluding</u> Health Savings Account		
1.	Furnishing CHLIC's standard Bank Account activity data reports to Employer as and when agreed upon. CHLIC's administration of the Plan does not include performing obligations, if any, under state escheat or unclaimed property laws. It is Employer's responsibility to determine the extent to which these laws may apply to the Plan and to comply with such laws.	**All Products**
2.	Report to Employer the claim payment information required in connection with Section 6041of the Internal Revenue Code.	**All Products**
3.	If Employer has elected, pursuant to section 63 of the New York Health Care Reform Act of 1996 (section 2807-t of the Public Health Law) ("the Act"), to pay the assessment on covered lives set forth in section 63 and has consented to the conditions set forth in section 63, CHLIC shall file such forms and pay such assessment on covered lives on behalf of Employer through the Bank Account to the extent set forth in section 63. Such obligation shall end immediately upon Employer's failure to provide any information required by CHLIC to fulfill this obligation, the failure to comply with any requirement imposed upon Employer pursuant to the Act or the failure of Employer to properly fund the Bank Account. In addition, where permitted, CHLIC will file applicable forms and pay on behalf of Employer and/or the Plan any assessment, surcharge, tax or other similar charge which is required to be made by you or the Plan based on covered lives and/or paid claims or otherwise in accordance with and as required by other applicable state and/or federal laws and regulations and your bank account will be charged for any such payments made by CHLIC.	**All Products**
CLAIM ADMINISTRATION		
Products <u>excluding</u> Health Savings Account		
1.	Calculate benefits, check and/or electronic payments disbursed from Employer's Bank Account. Bank Account payments will appear in Employer's standard Bank Account activity data reports.	**All Products**
2.	CHLIC's generic claim forms are made available to Employer for individuals eligible to enroll in the Plan.	**All Products**
3.	Investigate claims, as necessary, by CHLIC's Special Investigations Unit.	**All Products**
4.	Discuss claims, when appropriate, with providers of health services.	**All Products**
5.	Perform, based on CHLIC's book of business internal audits of plan benefit payments on a random sample basis.	**All Products**
6.	Claim control procedures reported annually in Statement on Standards for Attestation Engagements (SSAE) No. 16 Report (SAS70 successor report).	**All Products**
7.	Respond to Insurance Department complaints.	**All Products**

8.	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Products**
9.	Member Explanation of Benefit (“EOB”) statements including, when applicable, notice of denied claims, denial reason(s) and appeal rights.	**All Products (excluding Pharmacy)**
10.	Verify enrollment and eligibility using Member information submitted by Employer and/or its authorized agent.	**All Products**
	Medical Only	
1.	CHLIC’s generic enrollment form is made available to Employer for individuals eligible to enroll in the Plan.	**All Medical Products**
2.	CHLIC’s standard ID card with toll-free telephone number are prepared and mailed directly to Members.	**All Medical Products**
3.	Administration of subrogation/conditional Claim Payment (terms described in Exhibit E).	**All Medical Products**
	Health Reimbursement Account (HRA), Healthy Awards (HA) and Healthy Future (HF) Only	
1.	Providing reimbursement request forms to Employer.	**HRA Products**
2.	Employer will make available specific funds to eligible employees enrolled in the HRA, HA and/or HF as applicable (**“Participating Members”**). At the end of each reimbursement period of the Plan Year, CHLIC shall issue payments to Participating Members (or their medical provider, if appropriate) to the extent of the maximum amount of payment allowed by Employer reduced by prior reimbursements for the same period of coverage, for the amount that is determined by it to be proper under the Plan.	**HRA Products**
3.	Allowable expenses for reimbursement under a HRA, HA and/or HF, as applicable, include all allowable health-related expenses, pursuant to I.R.C. Section 213 except where payment for any such products is prohibited. The Employer can further limit the allowable expenses as agreed to by the Employer during implementation.	**HRA Products**
4.	Account balances for Participating Members active until the end of the Plan Year will remain open after conclusion of the Plan Year for a period of one year, (the "**Run Out Period**"), so that such Participating Members can submit any remaining expenses incurred during the Plan Year.	**HRA Products**
5.	A Participating Member’s request to terminate his/her enrollment in the HRA, HA, and/or HF, as applicable, will continue to be processed for 90 days following termination for any expenses incurred prior to his/her Participating Membership termination date up to the originally selected goal amount, minus prior reimbursements.	**HRA Products**
6.	For reimbursement payments that are made as a result of automatic claim forwarding (“AutoPay”) of medical claims from a medical plan administered by CHLIC or Direct Submit Request For Reimbursement, an explanation of payment will be mailed to the Participating Member at their home address. An explanation of payment is not issued for payments that are issued to a pharmacy at the point of service as a result of AutoPay from the employee's pharmacy Plan or for any Debit Card transactions.	**HRA Products**
7.	Providing information on account balances and submitted claims to Participating Members calling the number on the ID card. In addition, Participating Members will have access to account information via Internet.	**HRA Products**
8.	When automatic claim forwarding (“AutoPay”) is turned on, medical claims processed but unpaid by CHLIC will be automatically submitted for reimbursement from the HRA and/or HA Participating Member’s HRA and/or HA account. Such “rollover” claims will be processed without additional submissions by the Participating Member.	**HRA Products**

9.	When CHLIC takes over HRA, HA and/or HF administration mid-Plan Year, CHLIC will provide administrative services from the date the Plan information is received.	**HRA Products**
10.	Pharmacy claims: Eligible pharmacy expenses, under the HRA and/or HA that are processed but unpaid by CHLIC may be automatically submitted ("rolled over") to the Reimbursement Accounts Claim Office for reimbursement from the Participating Member's HRA, HA and/or HF account if the AutoPay option is enabled. Such rollover claims will be processed without additional submissions by the Participating Member. When pharmacy is covered and Cigna Pharmacy is the pharmacy vendor, the HRA and/or HA will automatically pay the pharmacy through the HRA and/or HA at the point of sale for all Participating Member obligations under the pharmacy Plan including deductibles, copays, and/or coinsurance obligations. A Participating Member will not receive an Explanation of Benefits for these payments.	**HRA Products**
	PLAN BOOKLET	
	Products excluding Health Savings Account	
	Prepare and make accessible Member benefit booklet drafts to Employer.	**All Products**
	UNDERWRITING SERVICES	
1.	5500 Schedule C reporting.	**All Products**
2.	5500 Schedule A or Annual Reconciliation Disclosure reporting (when applicable)	**All Products**
3.	CHLIC's standard Underwriting services: a) benefit design analysis-b) projected cost analysis.	**All Products**
	HIPAA INDIVIDUAL RIGHTS	
	Products excluding Health Savings Account	
	Handling of requests from Members for access to, amendment and accounting of protected health information, and requests for restrictions and alternative communications as required under federal HIPAA law and regulations, as set out in this Agreement and its Exhibits.	**All Products**
	COST CONTAINMENT	
1.	Maximum reimbursable charge determinations of non-Participating Provider charges for covered services.	**All Medical Products (with out-of-network benefits)**
2.	CHLIC's standard cost containment controls: Application of non-duplication and coordination of benefits rules and coordination with Medicare.	**All Medical Products**
3.	Delivery of information, as necessary, regarding standard application of non-duplication or coordination of benefits.	**All Medical Products**
4.	Review of medical bills in accordance with CHLIC's then current Medical Bill Review program.	**All Medical Products**
5.	Network Savings Program, a national vendor network that provides discounted rates when a Member accesses care through a Network Savings Program contracted provider.	**All Medical Products**
6.	Annual reporting of CHLIC's standard cost containment results upon Employer's request.	**All Medical Products**
7.	Pharmacy Vendor Recoveries.	**All Pharmacy Products**

CUSTOMER REPORTING		
1.	Summary reports of medical and pharmacy cost and utilization experience are available through Cigna's web site, CignaAccess.com.	**All Medical and Pharmacy Products**
2.	CHLIC's standard pharmacy utilization reports.	**Pharmacy Product Only**
3.	Claim Reporting: CHLIC will provide standard banking and financial report information based upon paid claim data. CHLIC will not provide information on incurred-but-not reported claims, projected claims, pre-certifications of coverage, case management information or information on a Member's prognosis or course of treatment. Stop Loss Reporting is an optional service provided at an additional fee to Employers who have stop loss through another entity other than CHLIC. CHLIC will provide its standard reporting only after the stop loss carrier and Employer have executed CHLIC's standard Hold Harmless/Confidentiality Agreement.	**All Medical Products**
4.	CHLIC's standard Individual Summary Statements for applicable participating Members.	**HRA Products**
5.	CHLIC's standard Health Reimbursement Account, Healthy Awards and/or Healthy Future activity report for Employer.	**HRA Products**
COMPLIANCE		
	Employer directs CHLIC in administering the Health Care Flexible Spending Account, Healthy Awards, Healthy Futures and/or Health Reimbursement Account benefit to comply with COBRA as follows:	
1.	The HRA, HA and/or HF of each HRA, HA and/or HF Participating Member who experiences a qualifying event and elects continuation of account coverage in accordance with COBRA will be maintained similar to the maintenance of an active employee. HF Participating Members that have not met their vesting requirements determined by the plan are not required to be offered COBRA for the HF.	**HRA Products**
MEMBER EXTERNAL REVIEW PROGRAM		
	CHLIC contracts with three (3) independent review organizations that meet the Patient Protection and Affordable Care Act (PPACA) external review requirements. Members may appeal eligible claims to an external independent review organization which is selected by CHLIC on a random basis. If Employer has chosen not to participate in this program, the Employer may be responsible for making other arrangements to meet the Patient Protection and Affordable Care Act (PPACA) external review requirements.	**All Medical Products**
MEDICAL MANAGEMENT SERVICES		
	CHLIC provides integrated medical management that includes (depending upon the terms of the Plan) the following core services.	
1.	Pre-Admission Certification and Continued Stay Review (PAC/CSR) services to certify coverage of acute and sub-acute inpatient admissions/stays or provides guidance to appropriate alternative settings. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products**

2.	Case Management and Retrospective Review of Inpatient Care, a service designed to provide assistance to a Member who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support.	**All Medical Products**
3.	Assist providers with resources and tools to enable them to develop long term treatment plans in the management of chronic or catastrophic cases.	**All Medical Products**
4.	The Cigna HealthCare Healthy Babies® Program is a one-time educational mailing which provides Participants with prenatal care education and resources to help them better manage their pregnancy. Other benefits of this program include the 24-Hour Health Information Line℠ and pregnancy information on myCigna.com.	**All Medical Products**
5.	HealthCare Cost and Quality tools on myCigna.com	**All Medical Products**
6.	A panel of physicians and other clinicians to assess the safety and effectiveness of new and emerging medical technologies. The panel meets monthly to review and update coverage policies.	**All Medical Products**
7.	The 24-Hour Health Information Line℠ is a service that provides twenty-four (24) hour toll free access to nurses, who provide answers to healthcare questions, recommend appropriate settings for care and assist Participants in locating physicians. It also includes access to an extensive audio library on a wide range of medical topics.	**All Medical Products**
8.	Cigna LifeSOURCE Transplant Network® contracts with over seven hundred fifty (750) transplant programs at more than one-hundred sixty (160) independent transplant facilities and provides access to solid organ and bone marrow/stem cell transplantation while improving cost containment and reducing financial risk.	**All Medical Products**
9.	A health education program that delivers mailings to Members with certain conditions.	**All Medical Products Except Comprehensive and Indemnity**
10.	If behavioral health services are provided/arranged by Cigna Behavioral Health (CBH), CBH provides utilization review and case management for inpatient in-network behavioral health services.	**OAP, HRA OAP, and OAPIN Products Only CA/NC Members**
11.	If behavioral health services are provided/arranged by Cigna Behavioral Health (CBH), CBH provides utilization review and case management for both inpatient and outpatient, in-network behavioral health services.	**OAP, HRA OAP, and OAPIN Products Only Non CA/NC Members**
12.	Implement clinical quality measurements, track and validate performance and initiate continuous quality improvement.	**All Medical Products Except Comprehensive and Indemnity**
13.	Transition of care services to allow Members with defined conditions to continue treatment with non-Participating Providers after enrollment for continued uninterrupted care for a limited time.	**All Medical Products Except Comprehensive and Indemnity**

.14.	Focused utilization management of outpatient procedures and identification of appropriate alternatives. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products with PHS Plus**
	NETWORK MANAGEMENT SERVICES	
	CHLIC, and/or its affiliates or contracted vendors shall:	
1.	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, fixed per person per period, per diem charges, incentive bonuses, case rates, withholds etc.). The amount and type of negotiated reimbursement may vary depending upon the type of plan. For example, a hospital may accept less for patients enrolled in certain types of plans than others; In addition, CHLIC may contract with Participating Providers and other parties for performance-based incentive payments to promote quality of care, patient safety and cost efficiency.	**All Medical and Pharmacy Products**
2.	Credential and re-credential Participating Providers in accordance with CHLIC's credentialing requirements and ensure that third-party network vendors credential/re-credential Participating Providers in accordance with CHLIC's requirements;	**All Medical and Pharmacy Products**
3.	Monitor Participating Provider compliance with protocols and procedures for quality, Member satisfaction, and grievance resolution;	**All Medical and Pharmacy Products**
4.	Facilitate the identification of Participating Providers by Members; and	**All Medical and Pharmacy Products**
5.	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Medical and Pharmacy Products**

BEHAVIORAL HEALTH		
	CHLIC has contracted with an affiliate, Cigna Behavioral Health ("CBH"), to provide or arrange for the provision of managed in-network behavioral health services, CBH is a Participating Provider, and is reimbursed primarily on a monthly fixed fee basis. This fixed fee for CBH services will be paid as claims and will appear in Employer's monthly reporting and on financial documents. Such payments will be at the relevant monthly rates then in effect. The monthly rates paid to CBH vary depending on geographic location of Members and on benefit design, and may be subject to change. The rates will be made available upon request. The fixed fee also includes lifestyle management programs, a cognitive behavioral modification program, a Complex Psychiatric Case Management program, and a Narcotics Therapy Management program. Behavioral claims from a client specific network are not included in the behavioral monthly fixed fee and will be paid from the Bank Account. In some states, payment for behavioral health services must be paid on a fee-for-service basis. In these states, fee-for-service payments for behavioral health services and the CBH administrative fee (including the lifestyle management programs, a cognitive behavioral modification program a Complex Psychiatric Case Management program and a Narcotics Therapy Management program) will be paid from the Bank Account as claims and will appear in Employer's monthly reporting.	**These services are included in the following products: OAP, HRA OAP, and OAPIN**

CIGNA STAFF MODEL HEALTHPLAN SERVICES		
	The Cigna HealthCare of Arizona, Inc. staff model ("Cigna Medical Group") is a Participating Provider located in metropolitan Phoenix, Arizona. Plan Participants may at some time receive treatment from a Cigna Medical Group ("CMG") facility or provider even if they do not reside in Arizona (as when traveling). Plan Participants utilizing the IPA network will access certain specialty and/or ancillary services (including laboratory and urgent care services) through the CMG system. Lab services are not provided by CMG for Participants in PPO or EPO plans. Except as provided below, for covered services provided to Participants, CMG is paid at the rates in effect at the time of service (as may be revised from time to time). Representative rates for routinely performed services are attached. A complete copy of the rates is available on request under a mutually agreed nondisclosure agreement (NDA). If the Plan requires Participants to select a primary care physician (PCP), Phoenix area Participants who do not select a PCP during open enrollment may be assigned to a CMG PCP. CMG is paid for PCP-required Plans at the rates in effect at the time of service. Primary care services rendered to Participants in Open Access or LocalPlus Plans that do not provide for PCP assignment are paid at the rates then in effect, as described above. CMG may also receive applicable performance-based incentive payments for its participation in programs designed to improve quality, patient safety and affordability.	**All Medical Products**

CIGNA HEALTHCARE OF ARIZONA - CIGNA MEDICAL GROUP (CMG)
REPRESENTATIVE RATES FOR ROUTINELY PERFORMED MEDICAL SERVICES

EFFECTIVE JUNE 1, 2016

(Applicable to all Open Access Plus Products)

Department	CPT Code	Description	OAP Rate
All Departments	99213	OFFICE VISIT,EST EXP PROB FOC	$65.80
Adult Medicine	99396	WELL EXAM, EST, 40-64 YEARS	$102.94
Pediatrics	99392	WELL EXAM, EST, 1-4 YEARS	$85.77
Ophthalmology	66984	REMOVE CATARACT, INSERT LEN- Professional Fee only, at a facility	$700.01
Podiatry	11721	DEBRIDEMENT NAIL SIX OR MORE	$39.95
Radiology	71020	CHEST X-RAY, PA & LAT	$30.38
Radiology	G0202 + 77052	SCREENING MAMMOGRAPHY DIGITAL	$141.02
General Surgery	47562	LAPAROSCOPY;CHOLECYSTECTOMY- Professional Fee only, at a facility	$837.79
Optometry	92014	EYE EXAM & TREATMENT	$109.35
Lab	80053	COMPREHENSIVE METABOLIC PANEL	$14.87
Lab	80061	LIPID PANEL	$18.85
ASC (Ambulatory surgical center) / Endoscopy Suite	Grouper 2		$469.00
ASC (Ambulatory surgical center) / Endoscopy Suite	Grouper 8		$1,104.00

** Medicare does not assign (or may not yet have assigned) relative value units (RVUs) for certain service codes. Codes not valued by Medicare are referred to as "gap codes." For example, Medicare does not assign values for wellness service codes (99381-99397). Cigna Medical Group refers to The Essential RBRVS (Annual) guide to obtain relative values for such gap codes for billing purposes. Typically, Cigna pays CMG for gap codes not valued by Medicare either at the discounted fee schedule referenced above or, for new codes not yet valued by Medicare, at the same rate it pays its IPA providers.*

The Urgent Care case rate excluding radiology and laboratory services is $115.

CMG pharmacy rates (30-day supply):

Brand Name: AWP – 10.56% + $2.75 dispensing fee

Generic: AWP – 35% + $2.75 dispensing fee

Exhibit C – Claim Audit Agreement (Sample)

A. WHEREAS, Cigna Health and Life Insurance Company ("CHLIC") desires to cooperate with requests by _____________(" Employer") to permit an audit for the purposes set forth below and subject to Section 6 of the Administrative Services Only Agreement between CHLIC and Employer;

B. WHEREAS, _______________("Auditor") has been retained by Employer for the purpose of performing an audit ("Audit") of claims administered by CHLIC;

C. WHEREAS, the Auditor and the Employer recognize CHLIC's legitimate interests in maintaining the confidentiality of its claim information, protecting its business reputation, avoiding unnecessary disruption of its claim administration, and protecting itself from legal liability; and

NOW THEREFORE, IN CONSIDERATION of the premises and the mutual promises contained herein, CHLIC, the Employer and the Auditor hereby agree as follows:

1. Audit Specifications

The Auditor will specify to CHLIC in writing at least forty-five (45) days prior to the commencement of the Audit the following "Audit Specifications":

a. the name, title and professional qualifications of individual Auditors;
b. the Claim Office locations, if any, to be audited;
c. the Audit objectives;
d. the scope of the Audit (time period, lines of coverage and number of claims);
e. the process by which claims will be selected for audit;
f. the records/information required by the Auditor for purposes of the Audit; and
g. the length of time contemplated as necessary to complete the Audit.

2. Review of Specifications

CHLIC will have the right to review the Audit Specifications and to require any changes in, or conditions on, the Audit Specifications which are necessary to protect CHLIC's legal and business interests identified in paragraph C above.

3. Access to Information

CHLIC will make the records/information called for in the Audit Specifications available to the Auditor at a mutually acceptable time and place.

4. Audit Report

The Auditor will provide CHLIC with a true copy of the Audit's findings, as well as the Audit Report, if any, that is submitted to the Employer. Such copies will be provided to CHLIC at the same time that the Audit findings and the Audit Report are submitted to the Employer.

5. Comment on Audit Report

CHLIC reserves the right to provide the Auditor and the Employer with its comments on the findings and, if applicable, the Audit Report.

6. Confidentiality

The Auditor understands that CHLIC is permitting the Auditor to review the claim records/information solely for purposes of the Audit. Accordingly, the Auditor will ensure that all information pertaining to individual claimants will be kept confidential in accordance with all applicable laws and/or regulations. Without limiting the generality of the foregoing, the Auditor specifically agrees to adhere to the following conditions:

a. The Auditor shall not make photocopies or remove any of the claim records/information without the express written consent of CHLIC;

b. The Auditor agrees that its Audit Report or any other summary prepared in connection with the Audit shall contain no individually identifiable information.

7. Restricted Use of the Audit Information

With respect to persons other than the Employer, the Auditor will hold and treat information obtained from CHLIC during the Audit with the same degree and standard of confidentiality owed by the Auditor to its clients in accordance with all applicable legal and professional standards. The Auditor shall not, without the express written consent of CHLIC executed by an officer of CHLIC, disclose in any manner whatsoever, the results, conclusions, reports or information of whatever nature which it acquires or prepares in connection with the Audit to any party other than the Employer except as required by applicable law. The Auditor agrees to indemnify and to hold harmless CHLIC for any and all claims, costs, expenses and damages which may result from any breaches of the Auditor's obligations under paragraphs 6 and 7 of this Agreement or from CHLIC's provision of information to the Auditor. The Employer authorizes CHLIC to provide to the designated Auditor the necessary information to perform the audit in a manner consistent with all Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Privacy Standards and in compliance with the signed Business Associate Agreement ("BAA").

8. Termination

CHLIC may terminate this Agreement with prior written notice. The obligations set forth in Sections 4 through 7 shall survive termination of this Agreement.

Cigna Health and Life Insurance Company

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: ___________________________

Title: _________________________________

Date: _________________________________

Employer: __________________________

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: ____________________________

Title: _________________________________

Date: _________________________________

Auditor: __________________________

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: ___________________________

Title: _________________________________

Date: _________________________________

Exhibit D – [Reserved.]

Exhibit E – Conditional Claim/Subrogation Recovery Services

I. Plans Without CHLIC General Stop Loss Coverage

If Employer has not purchased individual or aggregate stop loss coverage from CHLIC or an affiliate with respect to its self-funded employee welfare benefit plan:

A. All conditional claim payment and/or subrogation recoveries under the Plan will be handled by the entity checked below;

___ Employer
___ An independent recovery vendor whose name and address follow:
___ CHLIC and its subcontractor(s)

B. If Employer has designated CHLIC and its subcontractors to act as its recovery agent in paragraph I.A. above, then:

i. Employer hereby confers upon CHLIC and its subcontractors' discretionary authority to reduce recovery amounts by as much as fifty percent (50%) of the total amount of benefits paid on Employer's behalf, and to enter into binding settlement agreements for such amounts.

ii. In the event a settlement offer represents a reduction greater than the percentage identified above, CHLIC and its subcontractors should seek settlement advice from:

Name:
Title:
Address:
Telephone:

iii. All amounts reimbursed to Employer's Bank Account shall be refunded at the gross amount. CHLIC's and it subcontractors' subrogation administration fee on cases where CHLIC and its subcontractors' have retained counsel and in cases where no counsel has been retained by CHLIC and its subcontractors are both reflected in the Schedule of Financial Charges**.**

C. Except where agreed to by CHLIC and Employer, CHLIC and its subcontractors shall have no duty or obligation to represent Employer in any litigation or court proceeding involving any matter which is the subject of this Agreement, but shall make available to Employer and/or Employer's counsel such information relevant to such action or proceeding as CHLIC and its subcontractors may have as a result of its handling of any matter under this Agreement.

D. In the event Employer purchases individual or aggregate stop loss coverage from CHLIC or an affiliate with respect to its self-funded employee welfare benefit plan at any time during the life of this Agreement, the provisions of paragraph II., below, shall control.

II. Plans with CHLIC Stop Loss Coverage

If Employer has purchased individual or aggregate stop loss coverage from CHLIC or an affiliate with respect to its self-funded employee welfare benefit plan:

A. CHLIC and its subcontractors shall have the right and responsibility to manage all conditional claim payment and/or subrogation recoveries under the Plan. CHLIC and its subcontractors shall reimburse to the Plan the recovery minus relevant individual and aggregate stop loss payments made by CHLIC.

B. All amounts reimbursed to Employer's Bank Account shall be refunded at the gross amount. CHLIC's and its subcontractors’ subrogation administration fee on cases where CHLIC and its subcontractors’ have retained counsel and in cases where no counsel has been retained by CHLIC and its subcontractors, are both reflected in the Schedule of Financial Charges.

C. CHLIC and its subcontractors shall have no duty or obligation to represent Employer in any litigation or court proceeding involving any matter which is the subject of this Agreement but shall make available to Employer and/or Employer's counsel such information relevant to such action or proceeding as CHLIC and its subcontractors may have as a result of its handling of any matter under this Agreement. Notwithstanding the foregoing, CHLIC and its subcontractors reserve to itself the right to retain counsel to represent CHLIC’s own interests in any subrogation and/or conditional claim recovery action under the Plan.

Contractual Agreements Unit
Underwriting
Cigna

Routing W122A
900 Cottage Grove Road
Hartford, CT 06152
Telephone 860.226.2785
Facsimile 860.730.3944
Victoria.sirica@cigna.com

March 18, 2020

Guy Hine
Risk Manager
City of Fort Lauderdale
100 North Andrews Avenue
Fort Lauderdale, FL 33301

RE: 2020 Plan Year Services and Charges (Effective January 1, 2020)

Account Name: City of Fort Lauderdale

Account Number(s): 3335139

Dear Guy Hine:

Cigna Health and Life Insurance Company ("**CHLIC**" or "Contractor") wants you to be aware of the services provided and charges that may be made by CHLIC and its affiliates in connection with the administration of your plan. Enclosed is a summary of the services for which you may be charged in connection with your Administrative Service Agreement with CHLIC.

The summary identifies the services that may apply to plans administered by CHLIC. Some specific services may not apply to your plan. Where a specific charge is identified, it is the charge in effect currently. Most charges are subject to change. To determine the current charge for any particular services in the future or for prior periods, and any other questions, please contact your Cigna sales representative.

Underwriting Contractual Agreements Unit

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SERVICES

Charges Processed Through Bank Account

Integrated Medical Management Fees

Charges may be processed through your bank account or directly billed to you as part of your Network Access Fee.

Your Health First

Charges may be processed through your bank account or directly billed to you as part of your Network Access Fee.

Your Health First is a disease management program that provides education, support and tools to help patient participants manage their conditions, support learning and reinforce positive self care behaviors, including: customized counseling by phone from a clinician, and educational materials appropriate to their specific diagnosis.

Cigna Behavioral Health

Charges may be processed through your bank account or directly billed to you as part of your Network Access Fee.

Behavioral health services are provided/arranged by Cigna Behavioral Health (CBH). CBH provides utilization review and case management for inpatient in-network behavioral health services.

- OAPIN Medical Products Only (CA/VI Members).

Behavioral health services are provided/arranged by Cigna Behavioral Health (CBH). CBH provides utilization review and case management for both inpatient and outpatient, in-network behavioral health services.

- HRA OAP and OAP Medical Products Only (All Members).
- OAPIN Medical Products Only (Non CA/VI Members).

Cigna Staff Model Healthplan(s)

The Cigna HealthCare of Arizona, Inc. staff model (“**Cigna Medical Group**” or "**CMG**") is a multispecialty participating provider group located in metropolitan Phoenix, Arizona. CMG's integrated care delivery model and population health management team work together to facilitate the way in which patients and doctors communicate and interact in order to increase patient satisfaction and improve health outcomes.

Plan Participants may at some time receive treatment from a CMG facility or provider even if they do not reside in Arizona (as when traveling). Plan Participants utilizing Cigna participating provider networks in Arizona may access certain specialty and/or ancillary services (such as imaging and urgent care services) through the CMG system.

For covered services provided to Participants, CMG is paid at the rates in effect at the time of service (as may be revised from time to time). Representative rates for routinely performed services are attached to the

Schedule of Financial Charges herein. A complete copy of the rates is available on request under a mutually agreed nondisclosure agreement ("**NDA**").

If the Plan requires or allows Participants to select a primary care provider ("**PCP**"), Phoenix area Participants who do not select a PCP during open enrollment may be assigned to or otherwise encouraged to consider a CMG PCP. CMG has established collaborative referral relationships with specialty and ancillary providers in Cigna's participating provider networks, which includes affiliated entities

CMG may also receive applicable performance-based incentive payments for its participation in programs designed to improve quality, patient safety and affordability. The incentive payments that CMG may receive will be determined using the same performance measures and reward formula as used in determining the incentive payments made to similarly situated non-Cigna affiliated provider entities. The amount of the incentive payments made to CMG and attributable to the plan will be provided upon request.

Schedule of Financial Charges

Certain fees and charges identified in this Schedule of Financial Charges will be billed to Employer monthly in accordance with CHLIC's then standard billing practices. However, CHLIC is authorized to pay all fees and charges from the Bank Account unless otherwise specified in this Agreement.

	MEDICAL ADMINISTRATION CHARGES	
Product	**Description**	**Charge**
Medical	Open Access Plus In-Network (OAPIN) with Care Management Preferred (ALL)	**$9.20/employee/month**
Medical	Open Access Plus (OAP) with Care Management Preferred (ALL)	**$9.20/employee/month**
Medical	HRA Open Access Plus (OAP) with Care Management Preferred (ALL)	**$9.20/employee/month**
	MEDICAL NETWORK ACCESS FEE, UTILIZATION MANAGEMENT FEE AND OPTIONAL PROGRAM FEE	
Product	**Description**	**Charge**
Medical	OAPIN Access Fee (ALL)	**$24.65/employee/month** **Includes $6.50 Base Access Fee, $8.10 HMCM Preferred, $5.25 Your Health First 200, $3.20 Health Advisor-A, $3.50 One Guide, $1.45 MotivateMe Value, less $3.35 account specific discount**

Medical	OAP Access Fee (ALL)	**$24.65/employee/month** **Includes $6.50 Base Access Fee, $8.10 HMCM Preferred, $5.25 Your Health First 200, $3.20 Health Advisor-A, $3.50 One Guide, $1.45 MotivateMe Value, less $3.35 account specific discount**
Medical	HRA OAP Access Fee (ALL)	**$21.42/employee/month** **Includes $6.50 Base Access Fee, $8.10 HMCM Preferred, $5.25 Your Health First 200, $3.50 One Guide, $1.45 MotivateMe Value, less $3.38 account specific discount**
	CIGNA CHOICE FUND AND OTHER CONSUMER DIRECTED ACCOUNT ADMINISTRATION SERVICES AND CHARGES	
	Product	**Charge**
	Cigna Choice Fund Health Reimbursement Account (HRA) Administration	**For HRA OAP Products: $4.50/employee/month**

<table>
<tr><td>Health Advisor – A</td><td>The Health Advisor program focuses on engaging targeted Members related to a variety of wellness and prevention topics, and is designed to facilitate healthy behaviors and promote achievement of health-related goals. The program includes the following components:

• Health and wellness coaching on high blood pressure, high cholesterol, healthy eating, physical activity and pre-diabetes using multiple coaching sessions, behavior modification techniques and other motivational interviewing and coaching styles to encourage behavior change that helps Participants reach established goals.
• Education and referral coaching on program topics with referral to appropriate internal and external resources available.
• Access to educational materials and web based Member tools and resources.
• Identification of gaps in care and outreach to Member to provide coaching for those identified with gaps for high cholesterol, high blood pressure, and additional coaching on other gaps in care will also occur.
• Support of Participants identified through predictive modeling with certain preference sensitive care conditions by supplying impartial evidence based medical information, to empower Participants to understand the potential benefits/ disadvantages of a specific course of action and make more informed care decisions.
• Answering health and medical related questions.
• Counseling Participants on prevention and the benefits of compliance with prescribed medications and treatments.</td><td>For HRA OAP Only: There is no additional charge for this program</td></tr>
<tr><td colspan="3">AMOUNTS OWED TO CHLIC</td></tr>
<tr><td colspan="3">Amounts paid by CHLIC with its own funds on behalf of Employer or the Plan with respect to charges for which Employer or the Plan is obligated to pay under this Agreement including Plan Benefits, Bank Account Payments (including fixed per person payments and pay-for-performance payments to Participating Providers), governmental taxes or assessments.</td></tr>
</table>

CIGNA HOME DELIVERY PHARMACY DISCLOSURE		
	Product	**Charge**
Cigna Home Delivery Pharmacy (a CHLIC affiliated company(ies))	Specialty drugs dispensed by Cigna Home Delivery Pharmacy and administered under the Plan's medical benefit. "Cigna Home Delivery Pharmacy" means a duly licensed pharmacy operated by CHLIC or its affiliates, where prescriptions are filled and delivered via the mail service, which may include, for example, Accredo Health Group, Inc., Tel-Drug of Pennsylvania LLC and Tel-Drug, Inc. Cigna Home Delivery Pharmacy may maintain product purchase discount arrangements and/or fee-for-service arrangements with pharmaceutical manufacturers and wholesale distributors. Cigna Home Delivery Pharmacy contract for these arrangements on its own account in support of its pharmacy operations. These arrangements relate to services provided outside of this Agreement and other pharmacy benefit management arrangements and may be entered into without regard to whether a specific drug is on one of the formularies that CHLIC offers to entities like Employer that sponsor group health plans. Discounts and fee-for-service payments received by Cigna Home Delivery Pharmacy are not part of the administrative fees or other charges paid to CHLIC in connection with CHLIC's services hereunder. This provision shall survive termination or expiration of the Agreement.	**The drug's charge under a national specialty drug discount schedule that generates a 12.5% annual average aggregate discount off AWP across specialty drug claims dispensed at Cigna Home Delivery Pharmacy to CHLIC's self-funded and insured group-client book of business.**
FEES FOR PROCESSING RUN-OUT CLAIMS		
OAPIN, OAP and HRA OAP	Run-Out Period of twelve (12) months	**No Additional Cost**

	CREDITS	
	CHLIC agrees to provide the City with either (i) a four (4) month fee credit when the City renews Medical and Pharmacy ASO Administration services with CHLIC or (ii) a six (6) month fee credit for the renewal of Medical and Pharmacy ASO Administration services and stop-loss coverage being retained by CHLIC.	
	SUBROGATION	
	Subrogation/Conditional Claim Payment. Identification, investigation and recovery of claim payments involving other party liability or where another entity is responsible for payment (including by way of example but not by limitation automobile insurance, homeowner insurance, commercial property insurance, worker's compensation). (This service is only provided with respect to Medical coverage).	**5% of recovery plus litigation costs if counsel is retained and an appearance is filed on behalf of CHLIC or Employer in any litigation, or a lawsuit is filed on their behalf;** **29% of recovery if no counsel is retained and in all other instances, including cases where state law requires that Employee benefit plans be named as party defendants or involuntary plaintiffs.**

CHLIC MEDICAL COST CONTAINMENT FEES

CHLIC administers the programs listed below to contain costs with respect to charges for health care service/supplies that are covered by the Plan (the "**Cost-Containment Programs**"). In administering these Cost-Containment Programs, CHLIC may contract with vendors to perform various Cost-Containment Program related services. Vendor fees generally range from 7-11% of gross savings. Specific vendor fees are available upon request subject to execution of a mutually agreed upon non-disclosure agreement to protect the proprietary vendor fee information from unauthorized use/disclosure. CHLIC's charge for administering a Cost-Containment Program is the percentage indicated below of either: (1) the "gross savings" (i.e., the difference between the charge the provider would have made and the charge the provider actually made as a result of the Cost-Containment Program). Any applicable vendor fee is included in CHLIC's charge and paid to the vendor by CHLIC; or (2) the "net savings" (i.e., the gross savings less the applicable vendor fee). With respect to only the "recovery," any applicable vendor fee is included in CHLIC's charge and paid to the vendor by CHLIC; or (3) the "recovery" (i.e., the amount recovered as a result of the Cost-Containment Program). Any applicable vendor fee is included in CHLIC's charge and paid to the vendor by CHLIC.

For charges for covered services received from a non-Participating Provider (including emergency/urgent care services that are covered at the in-network benefit level), CHLIC may apply discounts available under agreements with third parties or through negotiation of the non-Participating Provider's charges whether on a claim-by-claim basis or in advance of services being rendered. These programs are identified below as the Network Savings Program Supplemental Network, and Medical Bill Review (pre-payment). CHLIC charges the percentage shown for administering these programs. Applying these discounts may result in higher payments than if the maximum reimbursable charge is applied. Whereas application of the maximum reimbursable charge may result in the patient being balance billed for the entire unreimbursed amount, applying these discounts avoids balance billing and substantially reduces the patient's out-of pocket cost.

If no discount is available or negotiated, reimbursement will be based upon:

(i) If charges are not subject to CHLIC's benefit enhancement policy – the plan's maximum reimbursable charge (in which case the patient may be balance billed by the provider if the provider's charge exceeds the plan's maximum reimbursable charge); or

(ii) If charges are subject to CHLIC's benefit enhancement policy – depending upon the Employer's election:

a. the amount of provider's billed charge not exceeding the greater of a CHLIC determined percentage of the Medicare allowable amount (the 80th percentile of the reasonable and customary charge if there is no Medicare allowable charge) or the amount required by state or federal, law (in the case of emergency room services) for charges subject to CHLIC's benefit enhancement policy (patient may be balance billed by the provider if the provider's charge exceeds such amount), or

b. the provider’s billed charge.

This administration of charges for covered services from non-Participating Providers is consistent with the claim administration practices with respect to CHLIC's own health care insurance business where applicable.

1.	Network Savings Program	**29% of net savings**
2.	Supplemental Network	**29% of net savings**
3.	Medical Bill Review – (Pre-payment Cost Containment for Non-contracted claims):	
	Inpatient Hospital Bill Review	
	• Line Item Analysis	**Lesser of 5% of hospital bill or the gross savings achieved**
	• Professional Fee Negotiation	**29% of net savings**
	Outpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
	Physician/Professional Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
4.	Medical Bill Review – (Pre or Post-payment Cost Containment for Non-contracted and Contracted claims):	
	• Bill Audit	**29% of the gross savings/recovery achieved plus hospital fees or expenses passed through**

	Diagnosis Related Grouping (DRG) Validation/Audits and Recovery. An overpayment audit and recovery program in which CHLIC or its vendors review paid claim data to identify overpayments based on inaccurate DRG coding.	**29% of recovery plus any fees or expenses passed through by the hospital or regulatory agency**
	Medical Implant Device Audits	**29% of recovery**
5.	COB Vendor Recoveries [Exclusive of pharmacy programs where claims are adjudicated at time prescription is received.]	**29% of recovery**
6.	Secondary Vendor Recovery Program	**29% of recovery**
7.	Provider Credit Balance Recovery Program	**29% of recovery**
8.	High Cost Specialty Pharmaceutical Audits (this service is only provided with respect to Medical coverage)	**29% of recovery**
9.	Class Action Recoveries	**35% of recovery**
10.	Eligibility Overpayment Recovery Vendor Services. Identification and recovery of funds in situations where the overpayment is due to the late receipt of Member termination information. (This service is only provided with respect to Medical coverage).	**29% of recovery**
CARE MANAGEMENT/COST CONTAINMENT PROGRAM FEES		
	CHLIC arranges for third parties to provide care management services to: (i) contain the cost of specified health care services/items overall with respect to all plans insured and/or administered by CHLIC, and/or (ii) improve adherence to evidence based guidelines designed to promote patient safety and efficient patient care.	**Specific vendor fees and care management program services are available upon request.**
	In addition to such third parties, CHLIC has arranged for an affiliate, eviCore, to provide the following care management/cost-containment programs	
	• Pre-certification of coverage of radiation therapy services.	**$842.79 per episode of care (EOC)**
	• Pre-certification of coverage of oncology services.	**$581.00 per episode of care (EOC)**

	• Pre-certification of coverage of musculoskeletal therapy services *(If Employer has elected Basic Standard Medical Management (see Administration Charges section above) this program and charge is not applicable to that membership)*	**$0.34 PMPM**
	• Pre-certification of coverage of diagnostic cardiology services *(If Employer has elected Basic Standard Medical Management (see Administration Charges section above) this program and charge is not applicable to that membership)*	**$0.19 PMPM**
	CHLIC may revise charges/fees by giving Employer at least sixty (60) days' prior written notice.	
EXTERNAL REVIEW AND CONSULTATIVE REVIEW FEES		
	When a Member elects an External Review (as that term is defined in the Patient Protection and Affordable Care Act (PPACA)) of a benefit determination by an independent third party, the cost of a specific third party review is dependent on the nature and complexity of the issue on appeal. Third party review charges will be commensurate with the level of expertise necessary and the time required to complete the review.	**$500-$1,500 Review**
STRATEGIC ALLIANCES		
	CHLIC contracts directly or indirectly with other managed care entities and third party network vendors for access to their provider networks and discounts. These third parties charge either a network access fee, which is included in CHLIC's monthly charges, or a percentage of the savings realized on a claim by claim basis as a result of the application of their discounts. Charges based on percentage of savings may be paid from the Bank Account. Additional details regarding specific charges will be provided upon request.	**All Medical Products**
OTHER VENDORS AND HEALTH CARE SERVICES PROVIDERS		
	The fixed per person per period and/or fee-for-service charges that CHLIC has directly or indirectly negotiated with Participating Providers for in-network health care services and/or supplies will be paid as claims for Plan Benefits and will be used in calculating any applicable Member cost-sharing. In addition, performance-based payments to Participating Providers will be charged to the Bank Account. Such payments will be at the payment rates then in effect, which may be amended from time to time. The fixed per person per period and/or fee-for-service charges that CHLIC has directly or indirectly negotiated with various vendors that arrange for the provision of in-network health care services and/or supplies through their	**All Products**

	contracted networks of providers may be paid as claims for Plan Benefits and used in calculating any applicable Member cost-sharing. Additional details regarding charges and the identity of the parties arranging for the provision of in-network health care services and/or supplies will be made available upon request.	
NOTICE REGARDING PAYMENTS FROM THIRD PARTIES		
	CHLIC may directly or indirectly receive and retain payments under contracts with pharmaceutical manufacturers or third parties with respect to Members' utilization of the manufacturer's products covered under the Employer's Plan medical benefit. These payments may include rebates, service fees (e.g. administrative fees), or other remuneration. CHLIC directly or indirectly contracts with pharmaceutical manufacturers or other third parties or any remuneration on its own behalf and for its own benefit, and not on behalf of Employer or the Plan. Accordingly, CHLIC retains all right, title and interest to any and all such remuneration received from manufacturer; neither Employer, its Members, nor Employer's Plan retains any beneficial or proprietary interest in any such remuneration, which shall be considered part of the general assets of CHLIC. This provision shall survive termination or expiration of the Agreement.	**All Medical Products**
	From time to time, CHLIC, directly or through its affiliates, arranges with third parties (e.g., service vendors, provider network managers) to provide various services (e.g., cost-containment services or health care services) in connection with the Plan. CHLIC and its affiliates may receive payments from such third parties to help defray CHLIC's expenses associated with its implementation and/or ongoing administration of these arrangements or as a reimbursement for services or network access provided to such parties by CHLIC. CHLIC may also receive compensation from third-party vendors that Employer may retain based upon a referral from CHLIC or that Members may utilize following an introduction facilitated by CHLIC or an affiliate. CHLIC may also receive: • network administration fees from some providers participating in its provider network, • credits from banks on balances in accounts utilized to administer claims,	**All Products**

	• non-material incidental compensation/benefits from other source as a result of administering the Plan.	
COMPLIANCE ASSISTANCE		
	CHLIC shall provide the following services to assist Employer in meeting its compliance obligations under section 2715 of the Public Health Service Act as added by the Patient Protection and Affordable Care Act and applicable regulations with respect to the provision of the Summary of Benefits and Coverage ("**SBC**"), translation notice and glossary. Applicable to all medical plans including HRA and FSA which are considered "group health plans" subject to the SBC requirements.	
1.	Preparation of SBC, translation notice. CHLIC will not be responsible for any changes that Employer makes to the SBC.	**No charge**
2.	Provide SBC, translation notices prepared by CHLIC to Employer electronically as well as any updates or material modifications.	**No charge**
3.	Include in SBC a summary of benefits administered by carve-out vendor if Employer or carve-out vendor provides CHLIC with necessary carve-out benefit information at least twelve (12) weeks prior to the date the SBCs are to be delivered to Employer.	**$500 for each benefit option under the Plan for which carve-out vendor benefits are included in SBC**
ADDITIONAL SERVICES		
Service	**Description**	**Charge**
Behavioral Health	Access to inpatient behavioral health services and focused utilization review and case management for inpatient, in-network behavioral health services. Applicable only to Members in CA/VI.	**For OAPIN Products: Included in Medical Access Fee**

Health Advisor - A	The Health Advisor program focuses on engaging targeted Members related to a variety of wellness and prevention topics, and is designed to facilitate healthy behaviors and promote achievement of health-related goals. The program includes the following components: • Health and wellness coaching on high blood pressure, high cholesterol, healthy eating, physical activity and pre-diabetes using multiple coaching sessions, behavior modification techniques and other motivational interviewing and coaching styles to encourage behavior change that helps Participants reach established goals. • Education and referral coaching on program topics with referral to appropriate internal and external resources available. • Access to educational materials and web based Member tools and resources. • Identification of gaps in care and outreach to Member to provide coaching for those identified with gaps for high cholesterol, high blood pressure, and additional coaching on other gaps in care will also occur. • Support of Participants identified through predictive modeling with certain preference sensitive care conditions by supplying impartial evidence based medical information, to empower Participants' to understand the potential benefits/ disadvantages of a specific course of action and make more informed care decisions. • Answering health and medical related questions. • Counseling Participants on prevention and the benefits of compliance with prescribed medications and treatments.	**For OAPIN** **and OAP Products:** **$3.20/employee/month Included in Medical Access Fee**
Clinical Program	A targeted condition medication therapy management program in which CHLIC provides support for Members using specialty medications for certain chronic conditions and that are obtained or administered at retail pharmacies or outpatient, office or home health care settings. As part of the program, Members are counseled on their condition, medication side effects, and importance of adherence. For the sake of clarity, if a specialty pharmacy affiliate of CHLIC provides therapy management for specialty medications the pharmacy dispenses to Members, then it does so in its capacity as a specialty pharmacy and not on behalf of CHLIC; CHLIC does not exert direction or control over the pharmacists at any specialty pharmacy affiliate.	**For HRA OAP,** **OAPIN** **and OAP Products: Included at No Additional Cost**

Incentive Tracking for Management Wellness Plan	The City has a Management Wellness plan that provides management employees with a $500 incentive based on completion of the defined activities. Cigna agrees to track incentives for the City, however the City will indemnify Cigna and hold it harmless from and against all contractual or extra contractual claims, amounts, liabilities, reasonable costs and/or expenses (including attorney's fees and court costs) which Cigna or the City may incur in connection with such tracking or in connection with any judicial, quasi-judicial or administrative proceedings relating thereto.	
Your Health First	A proactive health education and improvement program for Members with a chronic condition. The program involves services that span across the Member's health needs. Behavioral coaching principles and evidence based medicine guidelines are utilized to optimize self-management skills and foster sustained health improvements. The program targets a chronic population at high risk for near term and future high cost medical expenses. Members are identified as having a chronic condition through a variety of sources which may include: claims data, referrals, and self-identification. A variety of resources is provided to those with a chronic condition, including access to online tools, personalized support, and targeted materials. The program includes the following components for those with a chronic condition: • Chronic condition-specific coaching • Pre- and post-discharge calls • Lifestyle management coaching: stress, weight management and tobacco cessation • Treatment decision support and coaching In order to continuously assess the effectiveness of the program and/or test new ideas to further engage Members around their health, a small sample of Members may be placed in a comparison group which for a defined period of time receives alternative services or is suppressed from receiving proactive outreach, such as engagement letters and/or calls. This could affect a few Members targeted for outreach during this limited time period.	**For HRA OAP,** **OAPIN** **and OAP Products:** **$5.25/employee/month Included in Medical Access Fee**

<table>
<tr><td>MotivateMe®
Incentives Program</td><td>The MotivateMe incentive program allows Employers to reward Members for taking steps to achieve health goals or make progress towards improving their health. Participating Members can earn rewards for active participation in CHLIC’s health improvement programs and activities that focus on prevention, lifestyle and behavior modification and disease management. Participating Members track their incentive activity online and earn rewards as has been designated per the Employer’s annual elections.

Reward types include: HRA and Healthy Awards Account fund deposits, debit and/or gift cards, and Employer self-administered awards such as HSA fund deposits, healthcare premium adjustment and payroll deposit.

Value Package – includes administration of Employer selected CHLIC standard Incentives Program which provides Participating Members with Employer’s pre-determined rewards. Activity to trigger incentives may include, but is not limited to, participation in the following available programs: Personal Health Analysis (CHLIC's health assessment), Social Health and Wellness, Wellness Screening (biometric), Online Health Coaching, Pre-Diabetes Digital Coaching, Self-Reported Activities, Steerage (Centers of Excellence facility steerage), Health Coaching by Phone, Case Management, Preventive Care (claim verified), and Employer specific programs.</td><td>For OAPIN,

OAP

and HRA OAP Products:

$1.45/employee/month Included in Medical Access Fee</td></tr>
<tr><td>One Guide</td><td>The One Guide advocacy solution utilizes a multimodal approach to support Member Participants and help them successfully navigate the health care system. Member Participants are serviced by personal guides that include frontline service staff, as well as clinicians and non-clinician support staff from our medical, behavioral and pharmacy programs.

In addition to connecting with personal guides via telephone, Member Participants can also interact with personal guides via the click-to-chat feature on myCigna.com (web and app), enabling Member Participants to engage with CHLIC and One Guide in the way in which they prefer. One Guide helps simplify and strengthen the connection between Member Participants, their benefit plan, and their overall health and well-being. Through personalized and relevant messaging, One Guide proactively engages Member Participants with clear</td><td>For OAPIN,

OAP

and HRA OAP Products:

$3.50/employee/month Included in Medical Access Fee</td></tr>
</table>

	ways to save money, stay healthy, and improve health outcomes that lead to a healthy lifestyle. One Guide offers: • education on health plan features, account balances and ways to maximize benefits and earn available incentives • guidance in finding the right doctor, lab, convenience care or pharmacy • immediate connection to health coaches and other resources The goal of One Guide is to help Members take care of what matters most- staying healthy, saving money, and improving health.	
Health Improvement Fund		
Health Improvement Fund	For clinical/wellness/behavioral programs offered by CHLIC that are purchased, CHLIC will establish a Health Improvement Fund in the amount of $87,000.00. This fund will be used to defray the cost of CHLIC designated and arranged health and wellness improvement programs (e.g. biometric screenings, flu shots) for Employees of Employer and to reward participation in these programs. The Health Improvement Fund is a one-time credit, however, unused funds can be rolled over each year. CHLIC must pre-approve use of the Health Improvement Fund. The Health Improvement Fund shall be extinguished upon notice of termination of this Agreement and any fund amount not used prior to the notice of termination of this Agreement shall only be available to Employer for the purpose of funding the cost of those reimbursable services provided prior to such notice of termination.	

Employee Assistance Program (EAP) EAP (continued)	CHLIC provides the Employee Assistance Program Services ("EAP") for EAP Participants through its affiliate experienced in establishing and administering an EAP, Cigna Behavioral Health, Inc. ("Cigna Behavioral"). The clinical component of the EAP provided to EAP Participants who reside in California or Nevada is covered under the short-term counseling policy(ies) issued to Employer by CHLIC and not by the terms of this Contract. All other EAP services for such EAP Participants who do not reside in California or Nevada are covered by the following terms. **EAP Participant:** Any person who is eligible to receive Cigna Behavioral EAP Services provided pursuant to this Agreement, including Employer's employees, their dependents and members of employees' households. **Clinical Services:** For mental health, alcoholism or drug abuse service ("Clinical Service"), assessment, referral and/or short-term problem resolution sessions will be provided, up to ten (10) visits per assessed problem. **Information Support Services:** For family care, legal/financial information, Healthy Rewards® discounts, online resources, and assessment and referral services as requested by EAP Participant or Employer will be provided. Legal assessment and referral services are not available to EAP Participants if the issue is related to a potential cause of action against Employer. Any additional services ("Menu Options") purchased by Employer are listed below. Services shall be provided by Cigna Behavioral through its employees and/or independent contractors. EAP Participant calls to the Cigna Behavioral toll-free number shall be handled by a personal advocate who shall refer the EAP Participant to an appropriate resource. a) For Clinical Services, Cigna Behavioral shall offer an appointment within two (2) business days with a local counselor. In a Clinical Services' emergency, trained clinicians shall be available at Cigna Behavioral to telephonically address the situation and to make a referral	

EAP (continued)	to a local counselor or crisis intervention center for assessment referral and/or short-term problem resolution. b) For Information Support Services, Cigna Behavioral may refer the EAP Participant to contracted specialty firms or to local resources for assessment and referral. Legal and/or financial services shall include, at no charge to EAP Participants, an initial thirty (30) minute consultation. EAP Participants shall be responsible for all other costs of services provided pursuant to a referral. Contracted specialty firms might offer the EAP Participant a discount rate. For Clinical Services, Cigna Behavioral shall maintain a nationwide network of local mental health and substance abuse counselors who shall assess the problem, provide short-term problem resolution and/or guide the EAP Participant to appropriate local treatment resources. Fees for Clinical Services other than assessment, referral and short-term problem resolution services within the maximum number of ten (10) visits per assessed problem shall be the EAP Participant's responsibility. Cigna Behavioral shall not represent to the EAP Participant that Cigna Behavioral's identification of or referral to treatment resources constitutes coverage under the provisions of EAP Participant's medical coverage plan. Communication materials related to EAP services are available electronically. Other EAP services Cigna Behavioral shall provide: a) Reports concerning utilization of EAP services by EAP Participants on a quarterly basis to Employer. Individually identifiable EAP Participant information shall be the property of Cigna Behavioral. Without the appropriate written consent of the EAP Participant, Cigna Behavioral shall provide no information to Employer or any third party that includes any EAP Participant specific identifiable information. Due to the sensitivity of EAP services, this provision is intended to be more stringent regarding the use or disclosure of PHI by Connecticut General and/or its other affiliates than the Business Associate Agreement and as such, this paragraph shall prevail over any other	

EAP (continued)	provision in the Agreement or any of its Schedules or Exhibits and/or their Attachments. b) Management consultations to supervisors who request assistance for work related problems of employees. Cigna Behavioral shall provide assistance with mandatory referrals for employees who are required, under continuation of employment, drug-free workplace or other workplace policies, to receive an assessment under the EAP. However, Cigna Behavioral shall not nor shall any of its network of providers provide advice and/or make a determination regarding an employee's (a) ability to safely perform the functions of his/her job, (b) ability to return to work after a medical disability, involuntary suspension from duties or administrative leave of absence, and/or (c) potential for workplace violence. No individually identifiable employee information concerning the employee's treatment shall be provided without the employee's written consent on a form approved by Cigna Behavioral. c) Employer Account Services: As part of Cigna's Fees, Employer has purchased a number of hours for each twelve (12) month period from the effective date of this Agreement for use in the delivery of the following Employer Account Services: (a.) Employee Orientation Sessions; (b.) Management/Supervisory Training sessions; (c.) Educational/Wellness Seminars; (d.) Critical Incident Response Services; and/or (e.) Other Employer Account Services, e.g. Employer Account Services requested by Employer for which Cigna Behavioral notifies Employer that those services shall be counted against Employer Account Services' hours, including but not limited to, executive briefings, reduction in workforce counseling, and Employer's on-site EAP promotional activities conducted by Cigna Behavioral EAP managers or Cigna Behavioral contracted EAP affiliates. The number of hours to be provided by Cigna Behavioral for Employer Account Services in each twelve (12) month period shall be **2 hours per 1,000** employees based on the number of employees reported by Employer on the first Cigna Behavioral bill for that period. Pro-rata adjustments in this number of hours may be computed pursuant to Section 8 of the Agreement. Delivery of these Employer Account Services shall be as agreed upon by the parties. In the event Employer does not utilize or only partially utilizes these Employer	

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<td>EAP (continued)</td>
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Account Services during the twelve (12) month period to which they relate, Employer shall not be entitled to any refund or account credit, or to carry those hours forward. If Employer cancels its request for these services or reduces the number of hours initially requested after an independent provider has been secured by Cigna Behavioral, Cigna Behavioral shall deduct that number of hours the provider had been secured from Employer Account Services' hours. Additional Employer Account Services' hours may be purchased by Employer from Cigna Behavioral at Cigna's Behavioral's then current fee-for-service rates in effect as of the date of request of such additional Employer Account Services' hours. Delivery of these additional Employer Account Services shall be as agreed upon by the parties.
Employer shall
a) Provide information to Participants regarding access to the communication materials described above, and shall cooperate with Cigna Behavioral in other reasonable efforts to otherwise communicate with EAP Participants concerning the services available to them pursuant to this Agreement.
b) Inform Cigna Behavioral of Employer's management policies and procedures that guide supervisors in handling employees with performance concerns in order for Cigna Behavioral to provide the training described above in Employer Account Services. Cigna Behavioral assumes no responsibility for the legal appropriateness of such policies and procedures.
c) Annually, within ninety (90) days of the anniversary date of this Agreement, furnish to Cigna Behavioral the number of employees who are only EAP Participants by state of residence. Such number would not include employees who are EAP Participants who also have coverage for Mental/Health Substance Abuse services under the Plan.
MENU OPTIONS
NONE
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CIGNA HEALTHCARE OF ARIZONA - CIGNA MEDICAL GROUP (CMG) REPRESENTATIVE RATES FOR ROUTINELY PERFORMED MEDICAL SERVICES

EFFECTIVE JANUARY 1, 2020

(Applicable to Open Access Plus Products)

Department	CPT Code*	Description	Rate
All Departments	99213	OFFICE VISIT,EST EXP PROB FOC	$73.81
Adult Medicine	99396	WELL EXAM, EST, 40-64 YEARS	$126.72
Pediatrics	99392	WELL EXAM, EST, 1-4 YEARS	$106.46
Ophthalmology	66984	REMOVE CATARACT, INSERT LENS- Professional Fee only, at a facility	$641.43
Podiatry	11721	DEBRIDEMENT NAIL SIX OR MORE	$45.51
Radiology	71046	CHEST X-RAY, PA & LAT	$31.28
Radiology	77067 & 77063	SCREENING MAMMOGRAPHY DIGITAL	$189.64
General Surgery	47562	LAPAROSCOPY;CHOLECYSTECTOMY- Professional Fee only, at a facility	$666.13
Optometry	92014	EYE EXAM & TREATMENT	$126.12
ASC (Ambulatory surgical center) / Endoscopy Suite	Grouper 2		$457.77
ASC Endoscopy Suite	Grouper 8		$998.69

** Medicare does not assign (or may not yet have assigned) relative value units (RVUs) for certain service codes. Codes not valued by Medicare are referred to as "gap codes." For example, Medicare does not assign values for wellness service codes (99381-99397). CMG refers to The Essential RBRVS (Annual) guide to obtain relative values for such gap codes for billing purposes. Typically, Cigna pays CMG for gap codes not valued by Medicare either at the discounted fee schedule referenced above or, for new codes not yet valued by Medicare, at the same rate it pays its other participating providers.*

The Urgent Care case rate excluding radiology and laboratory services is $135.

CMG pharmacy rates:

Brand Name: 30-day supply: AWP – 10.56% + $2.75 dispensing fee

90-day supply: AWP – 17.91% + $1.50 dispensing fee

Generic*: 30-day supply: AWP – 35% + $2.75 dispensing fee

90-day supply: AWP - 21% + $1.50 dispensing fee

** If MAC pricing is available for generic medication, rate is MAC + dispensing fee*

Victoria A. Sirica
Operations Senior Manager
Cigna

Routing W122A
900 Cottage Grove Road
Hartford, CT 06152
Telephone 860.226.2785
Facsimile 860.730.3944
Victoria.sirica@cigna.com

December 28, 2020

Guy Hine
Risk Manager
City of Fort Lauderdale
100 North Andrews Avenue
Fort Lauderdale, FL 33301

RE: Administrative Services Only Account No. 3335139

Dear Guy Hine:

This letter will serve as an amendment to the Administrative Services Only Agreement between Cigna Health and Life Insurance Company ("**CHLIC**") and City of Fort Lauderdale ("**Employer**"), effective January 1, 2017, (the "Agreement").

Effective as of January 1, 2021, the Agreement is hereby amended as set forth below. Any provision or subsection set forth in this Amendment shall be deemed to: (a) replace in its entirety the same subsection in the current Agreement; and/or (b) add new provisions or subsections. Only those provisions and subsections set forth in this Amendment are deemed amended or added, and all provisions and subsections not identified herein shall be deemed unaffected by this Amendment and, accordingly, shall remain in full force and effect.

Section 2.c of the Administrative Services Only Agreement is hereby amended in its entirety as follows:

c. Employer hereby delegates to CHLIC the authority, responsibility and discretion to determine coverage under the Plan based on the eligibility and enrollment information provided to CHLIC by Employer. Employer also hereby delegates to CHLIC the authority, responsibility and discretion to (i) make factual determinations and to interpret the provisions of the Plan to make coverage determinations on claims for Plan Benefits, (ii) conduct a full and fair review of each claim which has been denied as defined by ERISA, (iii) conduct level one of internal appeals of "Urgent Care Claims," "Concurrent," "Pre-service," and "Post-service" claims (as those terms are defined under ERISA) and notify the Member or the Member's authorized representative of its decision. Employer will ensure that all summary plan description materials provided to Members reflect the delegation of discretionary authority outlined above.

   If the Plan provides a level two internal appeal, Employer shall conduct and retain full responsibility and discretionary authority for such appeals including notification to the Member and/or the Member's authorized representative of its decision. Employer will ensure that the summary plan description materials provided to Members properly outline the internal appeal process and Employer's responsibility for level two internal appeals.

Section 3.d of the Administrative Services Only Agreement is hereby amended in its entirety as follows:

d. CHLIC will promptly adjust any underpayment of Plan Benefits or pay-for-performance payments by drawing additional funds due the claimant from the Bank Account. In the event CHLIC determines that it has overpaid a claim for Plan Benefits or paid Plan Benefits to the wrong party, it shall take all reasonable steps consistent with the policies and procedures applicable to its own health care

"Cigna" is a registered service mark and the "Tree of Life" logo is a service mark of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Cigna Health and Life Insurance Company, Cigna Health and Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

insurance business to recover the overpayments of Plan Benefits. CHLIC shall also take all reasonable steps consistent with the policies and procedures applicable to its own health care insurance business to collect pay-for-performance payments due to Employer or to recover pay-for-performance overpayments (collectively "Pay-for-Performance Recoveries"). CHLIC shall not be required to initiate court, mediation, arbitration or other administrative proceedings to recover any overpayment of Plan Benefits or to collect or recover Pay-for-Performance Recovery. However, when it elects to do so, CHLIC is expressly authorized by Employer to take all actions on behalf of the Employer and/or the Plan to pursue overpayment recovery of Plan Benefits or to collect or recover Pay-for-Performance Recovery including, but not limited to, retaining counsel, settling and compromising claims or Pay-for-Performance Recoveries, in which case CHLIC shall be responsible for the attorney fees, court costs or arbitration fees incurred by CHLIC in the specific overpayment recovery action of Plan Benefits (not applicable to subrogation or conditional claim payment recoveries) or to collect or recover Pay-for-Performance Recovery, but not any other associated third party costs absent consent of CHLIC. CHLIC shall not be responsible for reimbursing any unrecovered payments of Plan Benefits or Pay-for-Performance Recoveries unless made as a result of its gross negligence or intentional wrongdoing.

Section 5.a of the Administrative Services Only Agreement is hereby amended in its entirety as follows:

a. Eligibility Determinations and Information. Employer is responsible for administering Plan enrollment. In determining any person's right to benefits under the Plan, CHLIC shall rely upon enrollment and eligibility information provided by the Employer and CHLIC shall have no liability for administering the Plan in reliance upon enrollment and eligibility information provided by Employer. Such information shall identify the effective date of eligibility and the termination date of eligibility and shall be provided promptly on a monthly basis (unless otherwise agreed to in writing by CHLIC) to CHLIC in a format and with such other information as reasonably may be required by CHLIC for the proper administration of the Plan.

The Schedule of Financial Charges and Exhibit B, “Services” are hereby deleted in their entirety and replaced with the Schedule of Financial Charges and Exhibit B, “Services,” as attached hereto.

The terms of the Administrative Services Only Agreement identified above, as mentioned herein, will be effective as of January 1, 2021. Please indicate your agreement to the amendment by signing the enclosed copy of this letter where indicated and returning it to me. Alternatively, this amendment shall become effective on the effective date indicated unless Employer notifies CHLIC either electronically or in writing (at the address indicated above) within sixty (60) days of the date of this letter that it does not accept all the terms of this amendment notwithstanding any provision to the contrary in the Administrative Services Only Agreement. In that case, CHLIC shall cooperate to negotiate mutually agreeable terms with Employer. Once agreement with respect to the terms of the amendment is reached, the amendment will apply retroactively to the effective date.

Sincerely,

Victoria A. Sirica
Its Operations Senior Manager
Duly Authorized
Cigna Health and Life Insurance Company

Accepted by: **City of Fort Lauderdale**

By: ____

Name: ____

Title: ____

Executed this ____ day of ________, in the year ________

Schedule of Financial Charges

Certain fees and charges identified in this Schedule of Financial Charges will be billed to Employer monthly in accordance with CHLIC's then standard billing practices. However, CHLIC is authorized to pay all fees and charges from the Bank Account unless otherwise specified in this Agreement.

	MEDICAL ADMINISTRATION CHARGES	
Product	**Description**	**Charge**
Medical	Open Access Plus In-Network (OAPIN) with Care Management Preferred (All Plans)	**$9.38/employee/month**
Medical	Open Access Plus (OAP) with Care Management Preferred	**$9.38/employee/month**
Medical	HRA Open Access Plus (OAP) with Care Management Preferred (All Plans)	**$9.38/employee/month**
	MEDICAL NETWORK ACCESS FEE, UTILIZATION MANAGEMENT FEE AND OPTIONAL PROGRAM FEE	
Product	**Description**	**Charge**
Medical	OAPIN Access Fee (All Plans)	**$25.07/employee/month Included in Medical Administration Charge** **Includes $6.63 Base Access Fee, $8.26 HMCM Preferred, $5.36 Your Health First 200, $3.26 Health Advisor-A, $3.57 One Guide, $1.48 MotivateMe Value, less $3.49 account specific discount**

Medical	OAP Access Fee	**$25.07/employee/month Included in Medical Administration Charge** **Includes $6.63 Base Access Fee, $8.26 HMCM Preferred, $5.36 Your Health First 200, $3.26 Health Advisor-A, $3.57 One Guide, $1.48 MotivateMe Value, less $3.49 account specific discount**
Medical	HRA OAP Access Fee (All Plans)	**$21.78/employee/month Included in Medical Administration Charge** **Includes $6.63 Base Access Fee, $8.26 HMCM Preferred, $5.36 Your Health First 200, $3.57 One Guide, $1.48 MotivateMe Value, less $3.52 account specific discount**

	MULTI-YEAR CHARGE/FEE GUARANTEES	
	The maximum increase for the Medical Administration Charge(s) and Network Access Fee(s) for the 2022 Plan Year will be 2.00% over the 2021 Plan Year charges/fees. The above fee guarantees are not applicable to Pharmacy Administration Fee. The above charges/fees are guaranteed for the time periods identified above, provided, however, that CHLIC may revise the above charges/fees pursuant to Section 8 of this Agreement.	
	CIGNA CHOICE FUND AND OTHER CONSUMER DIRECTED ACCOUNT ADMINISTRATION SERVICES AND CHARGES	
	Product	**Charge**
	Cigna Choice Fund Health Reimbursement Account (HRA) Administration	**For HRA OAP Products: $4.50/employee/month**
Health Advisor – A	The Health Advisor program focuses on engaging targeted Members related to a variety of wellness and prevention topics, and is designed to facilitate healthy behaviors and promote achievement of health-related goals. The program includes the following components: • Health and wellness coaching on high blood pressure, high cholesterol, healthy eating, physical activity and pre-diabetes using multiple coaching sessions, behavior modification techniques and other motivational interviewing and coaching styles to encourage behavior change that helps Participants reach established goals. • Education and referral coaching on program topics with referral to appropriate internal and external resources available. • Access to educational materials and web based Member tools and resources. • Identification of gaps in care and outreach to Member to provide coaching for those identified with gaps for high cholesterol, high blood pressure, and additional coaching on other gaps in care will also occur. • Support of Participants identified through predictive modeling with certain preference	**For HRA OAP Only: Included in Medical Access Fee**

	sensitive care conditions by supplying impartial evidence based medical information, to empower Participants to understand the potential benefits/ disadvantages of a specific course of action and make more informed care decisions. • Answering health and medical related questions. • Counseling Participants on prevention and the benefits of compliance with prescribed medications and treatments.	

AMOUNTS OWED TO CHLIC

Amounts paid by CHLIC with its own funds on behalf of Employer or the Plan with respect to charges for which Employer or the Plan is obligated to pay under this Agreement including Plan Benefits, Bank Account Payments (including fixed per person payments and pay-for-performance payments to Participating Providers), governmental taxes or assessments will be billed to Employer and CHLIC is authorized to pay all such amounts from the Bank Account.

CIGNA HOME DELIVERY PHARMACY DISCLOSURE

	Product	Charge
Cigna Home Delivery Pharmacy (a CHLIC affiliated company(ies))	Specialty drugs dispensed by Cigna Home Delivery Pharmacy and administered under the Plan's medical benefit. "Cigna Home Delivery Pharmacy" means a duly licensed pharmacy operated by CHLIC or its affiliates, where prescriptions are filled and delivered via the mail service. Cigna Home Delivery Pharmacy may maintain product purchase discount arrangements and/or fee-for-service arrangements with pharmaceutical manufacturers and wholesale distributors. Cigna Home Delivery Pharmacy contract for these arrangements on its own account in support of its pharmacy operations. These arrangements relate to services provided outside of this Agreement and other pharmacy benefit management arrangements and may be entered into without regard to whether a specific drug is on one of the formularies that CHLIC offers to entities like Employer that sponsor group health plans. Discounts and fee-for-service payments received by Cigna Home Delivery Pharmacy are not part of the administrative fees or other charges paid to CHLIC in connection with CHLIC's services hereunder. This provision shall survive termination or expiration of the Agreement.	**The drug's charge under a national specialty drug discount schedule that generates a 12.5% annual average aggregate discount off AWP across specialty drug claims dispensed at Cigna Home Delivery Pharmacy to CHLIC's self-funded and insured group-client book of business.**

FEES FOR PROCESSING RUN-OUT CLAIMS		
OAPIN, OAP and HRA OAP	Run-Out Period of twelve (12) months	**No Additional Cost**

CHLIC MEDICAL COST CONTAINMENT FEES

CHLIC administers the programs listed below to contain costs with respect to charges for health care service/supplies that are covered by the Plan (the "**Cost-Containment Programs**").In administering these Cost-Containment Programs, CHLIC may contract with vendors to perform various Cost-Containment Program related services.

CHLIC's charge for administering a Cost-Containment Program is the percentage indicated in the table below of the:

1) "gross savings" (i.e., the difference between the charge the provider made and the allowable amount resulting from the Cost-Containment Program);

2) "net savings" (i.e., the gross savings less the applicable vendor charge); or

3) "gross recovery" (i.e., the amount recovered as a result of the Cost-Containment Program) as applicable.

CHLIC will make a per claim charge that includes both CHLIC's applicable Cost Containment Program charge, as shown in the table below, and the applicable vendor charge. CHLIC will pay the vendor its charge.

For charges for covered services received from a non-Participating Provider (including emergency/urgent care services that are covered at the in-network benefit level), CHLIC may apply discounts available under agreements with third parties or through negotiation of the non-Participating Provider's charges whether on a claim-by-claim basis or in advance of services being rendered. The programs for obtaining these discounts are identified in Section A of the table below as Non-Participating Provider Cost-Containment Programs. Applying these discounts may result in higher payments than if the maximum reimbursable charge is applied. Whereas application of the maximum reimbursable charge may result in the patient being balance billed for the entire unreimbursed amount, applying these discounts avoids balance billing and may substantially reduce the patient's out-of-pocket cost.

CHLIC's per claim charge for administering the Non-Participating Provider Cost-Containment Programs in Section A of the table below plus any per claim vendor charges associated with the Non-Participating Provider Cost-Containment Programs in Section A of the table shall not exceed

$30,000.00 per claim. Vendor charges for the Non-Participating Provider Cost-Containment Programs in Section A of the table generally range from 7-11% of gross savings. Specific rates charged by vendors for the programs in Section A of the table are available upon request, subject to execution of a mutually agreed upon non-disclosure agreement to protect the proprietary vendor information from unauthorized use/disclosure.

If no discount is available or negotiated, reimbursement will be based upon:

(i) If charges are not subject to CHLIC's benefit enhancement policy – the plan's maximum reimbursable charge (in which case the patient may be balance billed by the provider if the provider's charge exceeds the plan's maximum reimbursable charge); or

(ii) If charges are subject to CHLIC's benefit enhancement policy – depending upon the Employer's election:

a. the amount of provider's billed charge not exceeding the greater of a CHLIC determined percentage of the Medicare allowable amount (the 80th percentile of the reasonable and customary charge if there is no Medicare allowable charge) or the amount required by state or federal, law (in the case of emergency room services) for charges subject to CHLIC's benefit enhancement policy (patient may be balance billed by the provider if the provider's charge exceeds such amount), or

b. the provider's billed charge.

The administration of charges for covered services from non-Participating Providers described above is consistent with the claim administration practices with respect to CHLIC's own health care insurance business where applicable.

A. Non-Participating Provider Cost-Containment Programs

1.	Network Savings Program	**29% of net savings**
2.	Supplemental Network	**29% of net savings**
3.	Medical Bill Review – (Pre-payment Cost Containment for Non-contracted claims):	
	Inpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
	Outpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**

	Physician/Professional Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
B. Other Cost-Containment Programs		
1.	Medical Bill Review – (Pre or Post-payment Cost Containment for Non-contracted and Contracted claims):	
	• Bill Audit	**29% of the gross savings/gross recovery achieved plus hospital fees or expenses passed through**
	Diagnosis Related Grouping (DRG) Validation/Audits and Recovery. An overpayment audit and recovery program in which CHLIC or its vendors review paid claim data to identify overpayments based on inaccurate DRG coding.	**29% of gross savings/gross recovery plus any fees or expenses passed through by the hospital or regulatory agency**
	Medical Implant Device Audits	**29% of the gross savings/gross recovery**
2.	COB Vendor Recoveries [Exclusive of pharmacy programs where claims are adjudicated at time prescription is received.]	**29% of the gross recovery**
3.	Secondary Vendor Recovery Program	**29% of the gross recovery**
4.	Provider Credit Balance Recovery Program	**29% of the gross recovery**
5.	High Cost Specialty Pharmaceutical Audits (this service is only provided with respect to Medical coverage)	**29% of the gross recovery**

6.	Eligibility Overpayment Recovery Vendor Services. Identification and recovery of funds in situations where the overpayment is due to the late receipt of Member termination information. (This service is only provided with respect to Medical coverage).	**29% of the gross recovery**
7.	Class Action Recoveries	**35% of the gross recovery**
8.	Subrogation/Conditional Claim Payment. Identification, investigation and recovery of claim payments involving other party liability or where another entity is responsible for payment (including by way of example but not by limitation automobile insurance, homeowner insurance, commercial property insurance, worker's compensation). (This service is only provided with respect to Medical coverage.)	**5% of the gross recovery plus litigation costs if counsel is retained and an appearance is filed on behalf of CHLIC or Employer in any litigation, or a lawsuit is filed on their behalf;** **29% of the gross recovery if no counsel is retained and in all other instances, including cases where state law requires that employee benefit plans be named as party defendants or involuntary plaintiffs.**
EMBARC BENEFIT PROTECTION℠ A NETWORK SOLUTION FOR CERTAIN HIGH-COST GENE THERAPY DRUGS		
Embarc Benefit Protection	To provide financial protection from the high cost, CHLIC has contracted with an affiliate, eviCore ("eviCore" refers to eviCore healthcare MSI, LLC d/b/a/ eviCore healthcare and certain of its affiliates), to arrange for the provision of the following gene therapy drugs for Members when both drugs are covered by the Plan administered by CHLIC, and medically necessary (as determined by CHLIC) to treat the conditions indicated: i. Luxturna® to treat inherited form of progressive blindness	**$0.99 per Member/per month.** If, across eviCore's entire Embarc Benefit Protection book of business (Cigna and non-Cigna clients),

	ii. Zolgensma® to treat children under 2 years old with spinal muscular dystrophy (Luxturna is the registered trademark of Spark Therapeutics, Inc. and Zolgensma is the registered trademark of AveXis, Inc.) As a result of this network contracting arrangement, eviCore is in most cases the exclusive, in-network Participating Provider of these drugs. eviCore arranges for the provision of these drugs through its network of specialty pharmacies (including its affiliate, Accredo), and certain facilities authorized to administer the gene therapies by the drug manufacturers. eviCore will reimburse these specialty pharmacies and facilities at negotiated reimbursement rates. This network solution is called Embarc Benefit Protection. For arranging for the provision of these drugs, eviCore will be reimbursed by CHLIC on a fixed Per Member Per Month (PMPM) basis. eviCore's PMPM fee (which is subject to change) will be charged to the Bank Account one month in arrears. (e.g., eviCore's charges for January will be made in February.) These Bank Account Payments will appear in Employer's monthly reporting. Embarc Benefit Protection does not provide financial protection from the cost of administering the two drugs. These costs are small in comparison to the drug costs. When covered under the Plan and determined by CHLIC to be medically necessary for the treatment of the specified conditions, Members will not incur any out-of-pocket costs for the two drugs and the Plan will not be required to reimburse any expenses for the two drugs with two exceptions: <u>Exceptions</u>: 1. For Members born before the date that Embarc Benefit Protection is effective for the Plan and receiving Zolgensma,® the Plan's in-network reimbursement and the Member's in-network cost-sharing apply to either (as applicable): • eviCore's fee-for-service charge for Zolgensma® when provided through Accredo: Average Wholesale Price (AWP) minus 15.8% AWP (based on Medispan) = $2,550,000, or	eviCore's cost for the two (2) drugs provided in a given calendar year is lower than a predetermined percentage of the PMPM charges received, eviCore will refund the difference pro rata, after having fully recovered the outstanding balance created by any prior year deficits. The refund, in any, will be determined on an eviCore Embarc benefit Protection book-of-business basis. The refund will be provided by March 31st of the following year. Assuring Transparency: After the refund is made for a particular calendar year, eviCore will, upon request, provide Embarc Benefit Protection book-of-business information for that calendar year.

	• the reimbursement rate of the participating facility or specialty pharmacy. 2. Members with an HSA must have met the applicable minimum deductible required for a high deductible health plan. **eviCore's Embarc Benefit Protection and PMPM charge do not apply to a plan that:** i. does not cover either or both drugs; ii. covers both drugs under its pharmacy benefits which are not administered by CHLIC, or iii. does not utilize a Cigna participating provider network. Upon Employer's request on or after the Effective Date, CHLIC shall provide to Employer an updated drug list, if applicable. CHLIC may revise charges/fees by giving Employer at least thirty (30) days' prior written notice.	
CARE MANAGEMENT/COST CONTAINMENT PROGRAM FEES		
	CHLIC arranges for third parties to provide care management services to: (i) contain the cost of specified health care services/items overall with respect to all plans insured and/or administered by CHLIC, and/or (ii) improve adherence to evidence based guidelines designed to promote patient safety and efficient patient care.	**Specific vendor fees and care management program services are available upon request.**
	In addition to such third parties, CHLIC has arranged for an affiliate, eviCore, to provide the following care management/cost-containment programs	
	• Pre-certification of coverage of radiation therapy services.	**$842.79 per episode of care (EOC)**

	• Pre-certification of coverage of diagnostic cardiology services *(If Employer has elected Basic Standard Medical Management (see Administration Charges section above) this program and charge is not applicable to that membership)*.	**$0.19 PMPM**
	• Effective February 1, 2021, network management and care coordination of coverage of home health, durable medical equipment and home infusion services.	**$0.30 PMPM**
	• Pre-certification of coverage of medical oncology services.	**$816.00 per episode of care (EOC)**
	• Pre-certification of coverage of musculoskeletal therapy services *(If Employer has elected Basic Standard Medical Management (see Administration Charges section above) this program and charge is not applicable to that membership)*.	**$0.37 PMPM**
	• Services related to the coverage of high tech radiology which may include pre-certification. In certain instances, the Plan will pay eviCore a fee on a per member/per month basis for pre-certification, arranging care, and other services that eviCore may render. Such reimbursement will be in addition to the amount that the Plan pays to reimburse the provider through which eviCore arranged for the provision of the service or supply, which will be based on eviCore's contracted rate with that provider. In such instances, Plan Benefits and member cost-share will be determined based on the rate that eviCore contracted to pay the provider for the provision of the service or supply. *(If Employer has elected Basic Standard Medical Management (see Administration Charges section above) this program and a charge is not applicable to that membership).* eviCore may also charge for services related to the provision of high tech radiology as described below in "Other Vendors and Health Care Services Providers."	**Fee reimbursement method and rates may vary by market and are available upon request**

	• Effective February 1, 2021, pre-certification of coverage of sleep management services *(If Employer has elected Basic Standard Medical Management (see Administration Charges section above) this program and charge is not applicable to that membership)*	**$0.10 PMPM**
	CHLIC may revise charges/fees by giving Employer at least sixty (60) days' prior written notice.	
EXTERNAL REVIEW AND CONSULTATIVE REVIEW FEES		
	When a Member elects an External Review (as that term is defined in the Patient Protection and Affordable Care Act (PPACA)) of a benefit determination by an independent third party, the cost of a specific third party review is dependent on the nature and complexity of the issue on appeal. Third party review charges will be commensurate with the level of expertise necessary and the time required to complete the review.	**$500-$1,500 Review**
STRATEGIC ALLIANCES		
	CHLIC contracts directly or indirectly with other managed care entities and third party network vendors for access to their provider networks and discounts. These third parties charge either a network access fee, which is included in CHLIC's monthly charges, or a percentage of the savings realized on a claim by claim basis as a result of the application of their discounts. Charges based on percentage of savings may be paid from the Bank Account. Additional details regarding specific charges will be provided upon request.	**All Medical Products**
OTHER VENDORS AND HEALTH CARE SERVICES PROVIDERS		
	The fixed per person per period and/or fee-for-service charges that CHLIC has directly or indirectly negotiated with Participating Providers for in-network health care services and/or supplies will be charged to the Bank Account and will be used in calculating any applicable Member cost-sharing. In addition, performance-based payments to Participating Providers will be charged to the Bank Account. Such payments will be at the payment rates then in effect, which may be amended from time to time. For certain types of specialty care, including, but not limited to, home health care, durable medical equipment, sleep management, high tech radiology, chiropractic care, physical medicine (such as physical and occupational therapy), speech therapy, orthotics and prosthetics, implants, and hearing, in certain markets CHLIC may contract with various third	**All Products**

parties and/or affiliated companies, including eviCore, ("Specialty Vendors") to arrange for the provision of care through their own networks of health care providers on a fee-for-service basis. In addition to arranging for care through their own networks of providers, these Specialty Vendors may also provide additional services, including utilization management services and case management services designed to (i) improve adherence to coverage guidelines; and (ii) contain overall healthcare costs to the Plan. Specialty Vendors are included within the definition of "Participating Provider" set forth in this Agreement and in any benefit booklet covering the Plan.

When care is arranged through a Specialty Vendor's network of providers, the form of reimbursement to the Specialty Vendor will be through one of the following methods:

- Fee-For-Service Payment: In certain instances, the Plan will pay the Specialty Vendor rather than the treating provider on a fee-for-service basis as a claim for Plan Benefits. The Specialty Vendors' fee-for-service charges may be higher than the amounts that the Specialty Vendor contracts to pay the provider for the provision of any particular service or supply, and some portion of the Specialty Vendor's charges may be attributable to the services that the Specialty Vendor provides in addition to those services or supplies provided by the Specialty Vendor's network of providers, including any utilization management services and case management services. In such instances, Plan Benefits and member cost-share will be determined based on the Specialty Vendor's charges according to Plan terms.
- Administration Capitation Payment: In certain instances, the Plan will pay the Specialty Vendor a fee on a per member/per month basis for arranging care and other services that the Specialty Vendor may render. Such reimbursement will be in addition to the amount that the Plan pays to reimburse the provider through which the Specialty Vendor arranged for the provision of the service or supply, which will be based on the Specialty Vendor's contracted rate with that provider. In such instances, Plan Benefits and member cost-share will be determined based on the rate that the Specialty Vendor contracted to pay the provider for the provision of the service or supply.
- All-Inclusive Capitation Payment: In certain instances, the Plan will pay the Specialty Vendor a fee on a per member/per month basis that covers (i) the services that the Specialty Vendor may render, including arranging care, and (ii) the fees charged by the

	provider through which the Specialty Vendor arranged for the provision of the service or supply. In such instances, Plan Benefits and member cost-share will be determined based on the rate that the Specialty Vendor contracted to pay the provider for the provision of the service or supply. CHLIC's arrangements with Specialty Vendors are subject to change at any time, and upon request, additional information can be provided that identifies current Specialty Vendors, their area of specialty(ies), whether they are CHLIC affiliates, and the form of payment that they currently receive.	
	Notwithstanding the terms of the Plan, CHLIC shall not administer Member cost-sharing with respect to charges made by Cricket Health, Inc. for its personalized, evidence-based approach to managing chronic kidney disease and end-stage renal disease for clinically eligible Members in CA and such cost-sharing expenses shall, instead, be reimbursed by the Plan (not applicable if Employer has opted out).	**All Products (excluding HSA Products)**
NOTICE REGARDING PAYMENTS FROM THIRD PARTIES		
	CHLIC may directly or indirectly receive and retain payments under contracts with pharmaceutical manufacturers or third parties with respect to Members' utilization of the manufacturer's products covered under the Employer's Plan medical benefit. These payments may include rebates, service fees (e.g. administrative fees), or other remuneration. CHLIC directly or indirectly contracts with pharmaceutical manufacturers or other third parties or any remuneration on its own behalf and for its own benefit, and not on behalf of Employer or the Plan. Accordingly, CHLIC retains all right, title and interest to any and all such remuneration received from manufacturer; neither Employer, its Members, nor Employer's Plan retains any beneficial or proprietary interest in any such remuneration, which shall be considered part of the general assets of CHLIC. This provision shall survive termination or expiration of the Agreement.	**All Medical Products**
	From time to time, CHLIC, directly or through its affiliates, arranges with third parties (e.g., service vendors, provider network managers) to provide various services (e.g., cost-containment services or health care services) in connection with the Plan. CHLIC and its affiliates may receive payments from such third parties to help defray CHLIC's expenses associated with its implementation and/or ongoing administration of these arrangements or as a reimbursement for services or network access provided to such parties by CHLIC. CHLIC	**All Products**

	may also receive compensation from third-party vendors that Employer may retain based upon a referral from CHLIC or that Members may utilize following an introduction facilitated by CHLIC or an affiliate. CHLIC may also receive: • network administration fees from some providers participating in its provider network, • credits from banks on balances in accounts utilized to administer claims, • non-material incidental compensation/benefits from other source as a result of administering the Plan.	
	COMPLIANCE ASSISTANCE	
	CHLIC shall provide the following services to assist Employer in meeting its compliance obligations under section 2715 of the Public Health Service Act as added by the Patient Protection and Affordable Care Act and applicable regulations with respect to the provision of the Summary of Benefits and Coverage ("**SBC**"), translation notice and glossary. Applicable to all medical plans including HRA and FSA which are considered "group health plans" subject to the SBC requirements.	
1.	Preparation of SBC, translation notice. CHLIC will not be responsible for any changes that Employer makes to the SBC.	**No charge**
2.	Provide SBC, translation notices prepared by CHLIC to Employer electronically as well as any updates or material modifications.	**No charge**
3.	Include in SBC a summary of benefits administered by carve-out vendor if Employer or carve-out vendor provides CHLIC with necessary carve-out benefit information at least twelve (12) weeks prior to the date the SBCs are to be delivered to Employer.	**$500 for each benefit option under the Plan for which carve-out vendor benefits are included in SBC**

ADDITIONAL SERVICES		
Service	**Description**	**Charge**
Health Advisor - A	The Health Advisor program focuses on engaging targeted Members related to a variety of wellness and prevention topics, and is designed to facilitate healthy behaviors and promote achievement of health-related goals. The program includes the following components: • Health and wellness coaching on high blood pressure, high cholesterol, healthy eating, physical activity, and pre-diabetes using multiple coaching sessions, behavior modification techniques and other motivational interviewing and coaching styles to encourage behavior change that helps Participants reach established goals. • Education and referral coaching on program topics with referral to appropriate internal and external resources available. • Access to educational materials and web-based Member tools and resources. • Identification of gaps in care and outreach to Member to provide coaching for those identified with gaps for high cholesterol, high blood pressure, and additional coaching on other gaps in care will also occur. • Support of Participants identified through predictive modeling with certain preference sensitive care conditions by supplying impartial evidence based medical information, to empower Participants' to understand the potential benefits/ disadvantages of a specific course of action and make more informed care decisions. This feature is only available when claim data is provided. • Answering health and medical related questions. • Counseling Participants on prevention and the benefits of compliance with prescribed medications and treatments.	**For OAPIN** **and OAP Products:** **$3.26/employee/month Included in Medical Access Fee**

Clinical Program	A targeted condition medication therapy management program in which CHLIC provides support for Members using specialty medications for certain chronic conditions and that are obtained or administered at retail pharmacies or outpatient, office or home health care settings. As part of the program, Members are counseled on their condition, medication side effects, and importance of adherence. For the sake of clarity, if a specialty pharmacy affiliate of CHLIC provides therapy management for specialty medications the pharmacy dispenses to Members, then it does so in its capacity as a specialty pharmacy and not on behalf of CHLIC; CHLIC does not exert direction or control over the pharmacists at any specialty pharmacy affiliate.	**For HRA OAP,** **OAPIN** **and OAP Products: Included at No Additional Cost**
Incentive Tracking for Management Wellness Plan	The City has a Management Wellness plan that provides management employees with a $500 incentive based on completion of the defined activities. Cigna agrees to track incentives for the City, however the City will indemnify Cigna and hold it harmless from and against all contractual or extra contractual claims, amounts, liabilities, reasonable costs and/or expenses (including attorney's fees and court costs) which Cigna or the City may incur in connection with such tracking or in connection with any judicial, quasi-judicial or administrative proceedings relating thereto.	
Your Health First	A proactive health education and improvement program for Members with a chronic condition. The program involves services that span across the Member's health needs. Behavioral coaching principles and evidence based medicine guidelines are utilized to optimize self-management skills and foster sustained health improvements. The program targets a chronic population at high risk for near term and future high cost medical expenses. Members are identified as having a chronic condition through a variety of sources which may include: claims data, referrals, and self-identification. A variety of resources is provided to those with a chronic condition, including access to online tools, personalized support, and targeted materials. The program includes the following components for those with a chronic condition: • Chronic condition-specific coaching • Pre- and post-discharge calls • Lifestyle management coaching: stress, weight management and tobacco cessation	**For HRA OAP,** **OAPIN** **and OAP Products:** **$5.36/employee/month Included in Medical Access Fee**

	• Treatment decision support and coaching In order to continuously assess the effectiveness of the program and/or test new ideas to further engage Members around their health, a small sample of Members may be placed in a comparison group which for a defined period of time receives alternative services or is suppressed from receiving proactive outreach, such as engagement letters and/or calls. This could affect a few Members targeted for outreach during this limited time period.	
Motivate*Me*® Incentives Program	The Motivate*Me* incentive program allows Employers to reward Members for taking steps to achieve health goals or make progress towards improving their health. Participating Members can earn rewards for active participation in CHLIC's health improvement programs and activities that focus on prevention, lifestyle and behavior modification and disease management. Participating Members track their incentive activity online and earn rewards as has been designated per the Employer's annual elections. Reward types include: HRA and Healthy Awards Account fund deposits, debit and/or gift cards, and Employer self-administered awards such as HSA fund deposits, healthcare premium adjustment and payroll deposit.	
	Value Package - includes administration of Employer selected CHLIC standard Incentives Program which provides Participating Members with Employer's pre-determined rewards. Activity to trigger incentives may include, but is not limited to, participation in the following available programs: Personal Health Analysis (CHLIC's health assessment), Social Health and Wellness, Wellness Screening (biometric), Online Health Coaching, Pre-Diabetes Digital Coaching, Self-Reported Activities, Steerage (Centers of Excellence facility steerage), Health Coaching by Phone, Case Management, Preventive Care (claim verified), and Employer specific programs.	**For OAPIN (MMe selection: OAME1,OAME2, OANM1, OANM2, ONM1F, ONM1L)** **and HRA OAP (MMe selection: HRAEM, HRAM1, HRAM2) Products:** **$1.48/employee/month Included in Medical Access Fee**

One Guide	The One Guide advocacy solution utilizes a multimodal approach to support Member and help them successfully navigate the health care system. Member are serviced by personal guides that include frontline service staff, as well as clinicians and non-clinician support staff from our medical, behavioral and pharmacy programs. In addition to connecting with personal guides via telephone, Member can also interact with personal guides via the click-to-chat feature on myCigna.com (web and app), enabling Member to engage with CHLIC and One Guide in the way in which they prefer. One Guide helps simplify and strengthen the connection between Member, their benefit plan, and their overall health and well-being. Through personalized and relevant messaging, One Guide proactively engages Member with clear ways to save money, stay healthy, and improve health outcomes that lead to a healthy lifestyle. One Guide offers: • education on health plan features, account balances and ways to maximize benefits and earn available incentives • guidance in finding the right doctor, lab, convenience care or pharmacy • immediate connection to health coaches and other resources The goal of One Guide is to help Members take care of what matters most- staying healthy, saving money, and improving health.	**For OAPIN,** **OAP** **and HRA OAP Products:** **$3.50/employee/month Included in Medical Access Fee**
Health Improvement Fund		
Health Improvement Fund	For clinical/wellness/behavioral programs offered by CHLIC that are purchased, CHLIC will establish a Health Improvement Fund in the amount of $87,000.00. This fund will be used to defray the cost of CHLIC designated and arranged health and wellness improvement programs (e.g. biometric screenings, flu shots) for Employees of Employer and to reward participation in these programs. The Health Improvement Fund is a one-time credit to be used from January 1, 2021-December 31, 2021. Unused funds cannot be rolled over and CHLIC must pre-approve use of the Health Improvement Fund.	

	The Health Improvement Fund shall be extinguished upon termination of this Agreement and any fund amount not used prior to termination of this Agreement shall only be available to Employer for the purpose of funding the cost of those reimbursable services provided prior to such termination.	
Employee Assistance Program (EAP)	CHLIC provides the Employee Assistance Program Services (“EAP”) for EAP Participants through its affiliate experienced in establishing and administering an EAP, Cigna Behavioral Health, Inc. (“Cigna Behavioral”). The clinical component of the EAP provided to EAP Participants who reside in California or Nevada is covered under the short-term counseling policy(ies) issued to Employer by CHLIC and not by the terms of this Contract. All other EAP services for such EAP Participants who do not reside in California or Nevada are covered by the following terms. **EAP Participant:** Any person who is eligible to receive Cigna Behavioral EAP Services provided pursuant to this Agreement, including Employer’s employees, their dependents and members of employees’ households. **Clinical Services:** For mental health, alcoholism or drug abuse service (“Clinical Service”), assessment, referral and/or short-term problem resolution sessions will be provided, up to ten (10) visits per assessed problem. **Information Support Services:** For family care, legal/financial information, Healthy Rewards® discounts, online resources, and assessment and referral services as requested by EAP Participant or Employer will be provided. Legal assessment and referral services are not available to EAP Participants if the issue is related to a potential cause of action against Employer. Any additional services (“Menu Options”) purchased by Employer are listed below. Services shall be provided by Cigna Behavioral through its employees and/or independent contractors. EAP Participant calls to the Cigna Behavioral toll-free number shall be handled by a personal advocate who shall refer the EAP Participant to an appropriate resource. a) For Clinical Services, Cigna Behavioral shall offer an appointment within two (2) business	EAP fees for Members eligible for CHLIC medical benefits and for Members who are eligible for non-CHLIC medical benefits are billed by Cigna Behavioral as follows: **1-10 Clinical Services and Information Support services:** $2.13/employee/month

	days with a local counselor. In a Clinical Services' emergency, trained clinicians shall be available at Cigna Behavioral to telephonically address the situation and to make a referral to a local counselor or crisis intervention center for assessment referral and/or short-term problem resolution. b) For Information Support Services, Cigna Behavioral may refer the EAP Participant to contracted specialty firms or to local resources for assessment and referral. Legal and/or financial services shall include, at no charge to EAP Participants, an initial thirty (30) minute consultation. EAP Participants shall be responsible for all other costs of services provided pursuant to a referral. Contracted specialty firms might offer the EAP Participant a discount rate. For Clinical Services, Cigna Behavioral shall maintain a nationwide network of local mental health and substance abuse counselors who shall assess the problem, provide short-term problem resolution and/or guide the EAP Participant to appropriate local treatment resources. Fees for Clinical Services other than assessment, referral and short-term problem resolution services within the maximum number of ten (10) visits per assessed problem shall be the EAP Participant's responsibility. Cigna Behavioral shall not represent to the EAP Participant that Cigna Behavioral's identification of or referral to treatment resources constitutes coverage under the provisions of EAP Participant's medical coverage plan. Communication materials related to EAP services are available electronically. Other EAP services Cigna Behavioral shall provide: a) Reports concerning utilization of EAP services by EAP Participants on a quarterly basis to Employer. Individually identifiable EAP Participant information shall be the property of Cigna Behavioral. Without the appropriate written consent of the EAP Participant, Cigna Behavioral shall provide no information to Employer or any third party that includes any EAP Participant specific identifiable information. Due to the sensitivity of EAP services, this provision is intended to be more stringent regarding the use or disclosure of PHI by Connecticut General and/or its other affiliates than the Business Associate	

	Agreement and as such, this paragraph shall prevail over any other provision in the Agreement or any of its Schedules or Exhibits and/or their Attachments. a) Management consultations to supervisors who request assistance for work related problems of employees. Cigna Behavioral shall provide assistance with mandatory referrals for employees who are required, under continuation of employment, drug-free workplace or other workplace policies, to receive an assessment under the EAP. However, Cigna Behavioral shall not nor shall any of its network of providers provide advice and/or make a determination regarding an employee's (a) ability to safely perform the functions of his/her job, (b) ability to return to work after a medical disability, involuntary suspension from duties or administrative leave of absence, and/or (c) potential for workplace violence. No individually identifiable employee information concerning the employee's treatment shall be provided without the employee's written consent on a form approved by Cigna Behavioral. b) Employer Account Services: As part of Cigna's Fees, Employer has purchased a number of hours for each twelve (12) month period from the effective date of this Agreement for use in the delivery of the following Employer Account Services: (a.) Employee Orientation Sessions; (b.) Management/Supervisory Training sessions; (c.) Educational/Wellness Seminars; (d.) Critical Incident Response Services; and/or (e.) Other Employer Account Services, e.g. Employer Account Services requested by Employer for which Cigna Behavioral notifies Employer that those services shall be counted against Employer Account Services' hours, including but not limited to, executive briefings, reduction in workforce counseling, and Employer's on-site EAP promotional activities conducted by Cigna Behavioral EAP managers or Cigna Behavioral contracted EAP affiliates. The number of hours to be provided by Cigna Behavioral for Employer Account Services in each twelve (12) month period shall be **2 hours per 1,000** employees based on the number of employees reported by Employer on the first Cigna Behavioral bill for that period. Pro-rata adjustments in this number of hours may be computed pursuant to Section 8 of the Agreement. Delivery of these Employer Account Services shall be as agreed upon by the parties. In the event Employer does not utilize or only partially utilizes these Employer Account Services during the twelve (12) month period to which they relate, Employer shall	

not be entitled to any refund or account credit, or to carry those hours forward. If Employer cancels its request for these services or reduces the number of hours initially requested after an independent provider has been secured by Cigna Behavioral, Cigna Behavioral shall deduct that number of hours the provider had been secured from Employer Account Services' hours. Additional Employer Account Services' hours may be purchased by Employer from Cigna Behavioral at Cigna's Behavioral's then current fee-for-service rates in effect as of the date of request of such additional Employer Account Services' hours. Delivery of these additional Employer Account Services shall be as agreed upon by the parties.

Employer shall

a) Provide information to Participants regarding access to the communication materials described above, and shall cooperate with Cigna Behavioral in other reasonable efforts to otherwise communicate with EAP Participants concerning the services available to them pursuant to this Agreement.
b) Inform Cigna Behavioral of Employer's management policies and procedures that guide supervisors in handling employees with performance concerns in order for Cigna Behavioral to provide the training described above in Employer Account Services. Cigna Behavioral assumes no responsibility for the legal appropriateness of such policies and procedures.
c) Annually, within ninety (90) days of the anniversary date of this Agreement, furnish to Cigna Behavioral the number of employees who are only EAP Participants by state of residence. Such number would not include employees who are EAP Participants who also have coverage for Mental/Health Substance Abuse services under the Plan.

MENU OPTIONS

NONE

Exhibit B – Services

BANKING AND ADMINISTRATION		
Products excluding Health Savings Account		
	Furnishing CHLIC's standard Bank Account activity data reports to Employer as and when agreed upon. CHLIC's administration of the Plan does not include performing obligations, if any, under state escheat or unclaimed property laws. It is Employer's responsibility to determine the extent to which these laws may apply to the Plan and to comply with such laws.	**All Products**
	If Employer has elected, pursuant to section 63 of the New York Health Care Reform Act of 1996 (section 2807-t of the Public Health Law) ("the Act"), to pay the assessment on covered lives set forth in section 63 and has consented to the conditions set forth in section 63, CHLIC shall file such forms and pay such surcharge and assessment on covered lives on behalf of Employer through the Bank Account to the extent set forth in section 63. Such obligation shall end immediately upon Employer's failure to provide any information required by CHLIC to fulfill this obligation, the failure to comply with any requirement imposed upon Employer pursuant to the Act or the failure of Employer to properly fund the Bank Account. In addition, where permitted and agreed to by CHLIC, CHLIC will file applicable forms and pay on behalf of Employer and/or the Plan any assessment, surcharge, tax or other similar charge which is required to be made by Employer and/or the Plan based on covered lives and/or paid claims or otherwise in accordance with and as required by other applicable state and/or federal laws and regulations and the Bank Account will be charged for any such payments made by CHLIC.	**All Products**
CLAIM ADMINISTRATION		
Products excluding Health Savings Account		
	Calculate benefits, check and/or electronic payments disbursed from Employer's Bank Account. Bank Account payments will appear in Employer's standard Bank Account activity data reports.	**All Products**
	CHLIC's generic claim forms are made available to Employer for individuals eligible to enroll in the Plan.	**All Products**
	CHLIC's Special Investigations Unit will investigate, pend, recommend denial of claims in whole or in part, and/or reprocess claims, as appropriate.	**All Products**
	Discuss claims, when appropriate, with providers of health services.	**All Products**

	Perform, based on CHLIC's book of business internal audits of plan benefit payments on a random sample basis.	**All Products**
	Claim control procedures reported annually in Statement on Standards for Attestation Engagements (SSAE) No. 18 Report (or any applicable successor thereto).	**All Products**
	Respond to Insurance Department complaints.	**All Products**
	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Products**
	Member Explanation of Benefit ("**EOB**") statements including, when applicable, notice of denied claims, denial reason(s) and appeal rights.	**All Products (excluding Pharmacy)**
	Verify enrollment and eligibility using Member information submitted by Employer and/or its authorized agent.	**All Products**
Medical Only		
	CHLIC's generic enrollment form is made available to Employer for individuals eligible to enroll in the Plan.	**All Medical Products**
	CHLIC's standard ID card with toll-free telephone number are prepared and mailed directly to Members.	**All Medical Products**
	Administration of subrogation/conditional Claim Payment (terms described in Exhibit E).	**All Medical Products**
Health Reimbursement Account (HRA), Healthy Awards (HA) and Healthy Future (HF) Only		
	Providing reimbursement request forms to Employer.	**HRA Products**
	Employer will make available specific funds to eligible employees enrolled in the HRA, HA and/or HF as applicable (**"Participating Members"**). At the end of each reimbursement period of the Plan Year, CHLIC shall issue payments to Participating Members (or their medical provider, if appropriate) to the extent of the maximum amount of payment allowed by Employer reduced by prior reimbursements for the same period of coverage, for the amount that is determined by it to be proper under the Plan.	**HRA Products**
	Allowable expenses for reimbursement under a HRA, HA and/or HF, as applicable, include all allowable health-related expenses, pursuant to I.R.C. Section 213 except where payment for any such products is prohibited. The Employer can further limit the allowable expenses as agreed to by the Employer during implementation.	**HRA Products**

	Account balances for Participating Members active until the end of the Plan Year will remain open after conclusion of the Plan Year for a period of one year, (the "**Run Out Period**"), so that such Participating Members can submit any remaining expenses incurred during the Plan Year.	**HRA Products**
	A Participating Member's request to terminate his/her enrollment in the HRA, HA, and/or HF, as applicable, will continue to be processed for 90 days following termination for any expenses incurred prior to his/her termination date up to the originally selected goal amount, minus prior reimbursements.	**HRA Products**
	For reimbursement payments that are made as a result of automatic claim forwarding ("**AutoPay**") of medical claims from a medical plan administered by CHLIC or Direct Submit Request For Reimbursement, an explanation of payment will be made available to the Participating Member. An explanation of payment is not issued for payments that are issued to a pharmacy at the point of sale as a result of AutoPay from the employee's pharmacy Plan or for any Debit Card transactions.	**HRA Products**
	Providing information on account balances and submitted claims to Participating Members calling the number on the ID card. In addition, Participating Members will have access to account information via Internet and mobile app.	**HRA Products**
	When automatic claim forwarding ("**AutoPay**") is turned on, medical claims processed but unpaid by CHLIC will be automatically submitted for reimbursement from the HRA and/or HA Participating Member's HRA and/or HA account. Such "rollover" claims will be processed without additional submissions by the Participating Member.	**HRA Products**
	When CHLIC takes over HRA, HA and/or HF administration mid-Plan Year, CHLIC will provide administrative services from the date the Plan information is received.	**HRA Products**
	Pharmacy claims: Eligible pharmacy expenses, under the HRA, HA and/or HF that are processed but unpaid by CHLIC may be automatically submitted ("rolled over") to the Reimbursement Accounts Claim Office for reimbursement from the Participating Member's HRA, HA and/or HF account if the AutoPay option is enabled. Such rollover claims will be processed without additional submissions by the Participating Member. When pharmacy is covered and Cigna Pharmacy is the pharmacy vendor, the HRA, HA and/or HF will automatically pay the pharmacy through the HRA, HA and/or HF at the point of sale for all Participating Member obligations under the pharmacy Plan including deductibles, copays, and/or coinsurance obligations. A Participating Member will not receive an Explanation of Benefits for these payments.	**HRA Products**

PLAN BOOKLET		
Products excluding Health Savings Account		
	Prepare and make accessible Member benefit booklet drafts to Employer.	**All Products**
UNDERWRITING SERVICES		
	5500 Schedule C reporting.	**All Products**
	5500 Schedule A or Annual Reconciliation Disclosure reporting (when applicable)	**All Products**
	CHLIC's standard Underwriting services: a) benefit design analysis b) projected cost analysis.	**All Products**
HIPAA INDIVIDUAL RIGHTS		
Products excluding Health Savings Account		
	Handling of requests from Members for access to, amendment and accounting of protected health information, and requests for restrictions and alternative communications as required under federal HIPAA law and regulations, as set out in this Agreement and its Exhibits.	**All Products**
COST CONTAINMENT		
	Maximum reimbursable charge determinations of non-Participating Provider charges for covered services.	**All Medical Products (with out-of-network benefits)**
	CHLIC's standard cost containment controls: Application of non-duplication and coordination of benefits rules and coordination with Medicare.	**All Medical Products**
	Delivery of information, as necessary, regarding standard application of non-duplication or coordination of benefits.	**All Medical Products**
	Review of medical bills in accordance with CHLIC's then current Medical Bill Review program.	**All Medical Products**
	Network Savings Program, a national vendor network that provides discounted rates when a Member accesses care through a Network Savings Program contracted provider.	**All Medical Products**
	Annual reporting of CHLIC's standard cost containment results upon Employer's request.	**All Medical Products**
CUSTOMER REPORTING		
	Summary reports of medical cost and utilization experience (where applicable), upon completion of internal report generation, are available through Cigna's web site, CignaAccess.com.	**All Medical Products**
	Claim Reporting: CHLIC will provide standard banking and financial report information based upon paid claim data. CHLIC will not provide information on incurred-but-not reported claims, projected claims, pre-certifications of coverage, case management information or information on a	**All Medical Products**

	Member's prognosis or course of treatment.	
	Stop Loss Reporting is an optional service provided at an additional fee to Employers who have stop loss through another entity other than CHLIC. CHLIC will provide its standard reporting only after the stop loss carrier and Employer have executed CHLIC's standard Hold Harmless/Confidentiality Agreement.	**All Medical Products**
	CHLIC's standard Individual Summary Statements for applicable participating Members.	**HRA Products**
	CHLIC's standard Health Reimbursement Account, Healthy Awards and/or Healthy Future activity report for Employer.	**HRA Products**
COMPLIANCE		
	Employer directs CHLIC in administering the Health Care Flexible Spending Account, Healthy Awards, Healthy Futures and/or Health Reimbursement Account benefit to comply with COBRA as follows:	
	The HRA, HA and/or HF of each HRA, HA and/or HF Participating Member who experiences a qualifying event and elects continuation of account coverage in accordance with COBRA will be maintained similar to the maintenance of an active employee. HF Participating Members that have not met their vesting requirements determined by the plan are not required to be offered COBRA for the HF.	**HRA Products**
MEMBER EXTERNAL REVIEW PROGRAM		
	CHLIC contracts with a minimum of three (3) independent review organizations that meet the Patient Protection and Affordable Care Act (PPACA) external review requirements. Members may appeal eligible claims requiring medical judgment to an external independent review organization which is selected by CHLIC on a random basis. If Employer has chosen not to participate in this program, the Employer may be responsible for making other arrangements to meet the Patient Protection and Affordable Care Act (PPACA) external review requirements.	**All Medical Products**
MEDICAL MANAGEMENT SERVICES		
	CHLIC provides integrated medical management that includes (depending upon the terms of the Plan) the following core services.	
	Pre-Admission Certification and Continued Stay Review (PAC/CSR) services to certify coverage of acute and sub-acute inpatient admissions/stays or provides guidance to appropriate alternative settings. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products**

	Case Management, a service designed to provide assistance to a Member who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support.	**All Medical Products**
	Assist providers with resources and tools to enable them to develop long term treatment plans in the management of chronic or catastrophic cases.	**All Medical Products**
	The Cigna HealthCare Healthy Babies Program is an educational program which provides Participants with prenatal care education and resources to help them better manage their pregnancy. Other benefits of this program include the Health Information Line, high maternity and pregnancy information on myCigna.com.	**All Medical Products**
	HealthCare Cost and Quality tools available on myCigna.com and myCigna mobile app.	**All Medical Products**
	A panel of physicians and other clinicians to assess the safety and effectiveness of new and emerging medical technologies. The panel meets monthly to review and update coverage policies.	**All Medical Products**
	The Health Information Line is a service that provides twenty-four (24) hour toll free access to nurses, who provide answers to healthcare questions, recommend appropriate settings for care and assist Participants in locating physicians. It also includes access to an extensive audio library, available on myCigna.com, on a wide range of medical topics.	**All Medical Products**
	Cigna LifeSOURCE Transplant Network® contracts with more than one hundred sixty-five (165) independent transplant facilities which includes over seven hundred fifty (750) transplant programs and provides access to solid organ and bone marrow/stem cell transplantation while improving cost containment and reducing financial risk.	**All Medical Products**
	A health education program that delivers mailings to Members with certain conditions.	**All Medical Products**
	Behavioral health services are provided/arranged by Cigna Behavioral Health (CBH), CBH provides utilization review and case management for both inpatient and outpatient, in-network behavioral health services.	**HRA OAP,** **OAPIN** **and OAP Products:** **(All Members)**
	Implement clinical quality measurements, track and validate performance and initiate continuous quality improvement.	**All Medical Products**

	Transition of care services to allow Members with defined conditions to continue treatment with non-Participating Providers after enrollment for continued uninterrupted care for a limited time.	**All Medical Products Except Comprehensive and Indemnity**
	Focused utilization management of outpatient procedures and identification of appropriate alternatives. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products with Care Management Preferred**
NETWORK MANAGEMENT SERVICES		
	CHLIC, and/or its affiliates or contracted vendors shall:	
	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, fixed per person per period, per diem charges, incentive bonuses, case rates, withholds etc.). The amount and type of negotiated reimbursement may vary depending upon the type of plan. For example, a hospital may accept less for patients enrolled in certain types of plans than others. In addition, CHLIC may contract with Participating Providers and other parties (for example Independent Practice Associations) for performance-based incentive payments to promote quality of care, patient safety and cost efficiency.	**All Medical Products**
	Credential and re-credential Participating Providers in accordance with CHLIC's credentialing requirements and ensure that third-party network vendors credential/re-credential Participating Providers in accordance with CHLIC's requirements;	**All Medical Products**
	Monitor Participating Provider compliance with protocols and procedures for quality, Member satisfaction, and grievance resolution;	**All Medical Products**
	Facilitate the identification of Participating Providers by Members; and	**All Medical Products**
	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Medical Products**
	Access to online and/or on demand medical and health-related consultations via secure telecommunications technologies, telephones and internet where permitted only when delivered by a CHLIC contracted medical Telehealth network of providers (see details on myCigna.com).	**All Medical Products**

BEHAVIORAL HEALTH		
	CHLIC has contracted with an affiliate, Cigna Behavioral Health ("CBH"), to provide or arrange for the provision of managed in-network behavioral health services, CBH is a Participating Provider, and is reimbursed primarily on a monthly fixed fee basis. This fixed fee for CBH services will be paid as claims and will appear in Employer's monthly reporting and on financial documents. Such payments will be at the relevant monthly rates then in effect. The monthly rates paid to CBH vary depending on geographic location of Members and on benefit design, and may be subject to change. The rates will be made available upon request. The fixed fee also includes lifestyle management programs and a cognitive behavioral modification program. Behavioral claims from a client specific network are not included in the behavioral monthly fixed fee and will be paid from the Bank Account. In some states, payment for behavioral health services must be paid on a fee-for-service basis. In these states, fee-for-service payments for behavioral health services and the CBH administrative fee (including the lifestyle management programs and a cognitive behavioral modification program) will be paid from the Bank Account as claims and will appear in Employer's monthly reporting.	**These services are included in the following products:** **HRA OAP,** **OAPIN** **and OAP Products**
CIGNA STAFF MODEL HEALTHPLAN SERVICES		
	The Cigna HealthCare of Arizona, Inc. staff model ("**Cigna Medical Group**" or "**CMG**") is a multispecialty participating provider group located in metropolitan Phoenix, Arizona. CMG's integrated care delivery model and population health management team work together to facilitate the way in which patients and doctors communicate and interact in order to increase patient satisfaction and improve health outcomes. Plan Participants may at some time receive treatment from a CMG facility or provider even if they do not reside in Arizona (as when traveling). Plan Participants utilizing Cigna participating provider networks in Arizona may access certain specialty and/or ancillary services (such as imaging and urgent care services) through the CMG system. For covered services provided to Participants, CMG is paid at the rates in effect at the time of service (as may be revised from time to time). Representative rates for routinely performed services are attached to the Schedule of Financial Charges herein. A complete copy of the rates is available on request under a mutually agreed nondisclosure agreement ("**NDA**").	**All Medical Products**

	If the Plan requires or allows Participants to select a primary care provider ("**PCP**"), Phoenix area Participants who do not select a PCP during open enrollment may be assigned to or otherwise encouraged to consider a CMG PCP. CMG has established collaborative referral relationships with specialty and ancillary providers in Cigna's participating provider networks, which includes affiliated entities. CMG may also receive applicable performance-based incentive payments for its participation in programs designed to improve quality, patient safety and affordability. The incentive payments that CMG may receive will be determined using the same performance measures and reward formula as used in determining the incentive payments made to similarly situated non-Cigna affiliated provider entities. The amount of the incentive payments made to CMG and attributable to the plan will be provided upon request.	

CIGNA HEALTHCARE OF ARIZONA - CIGNA MEDICAL GROUP (CMG)
REPRESENTATIVE RATES FOR ROUTINELY PERFORMED MEDICAL SERVICES

EFFECTIVE JANUARY 1, 2020
(Applicable to Open Access Plus Products)

Department	CPT Code*	Description	Rate
All Departments	99213	OFFICE VISIT,EST EXP PROB FOC	$73.81
Adult Medicine	99396	WELL EXAM, EST, 40-64 YEARS	$126.72
Pediatrics	99392	WELL EXAM, EST, 1-4 YEARS	$106.46
Ophthalmology	66984	REMOVE CATARACT, INSERT LENS-Professional Fee only, at a facility	$641.43
Podiatry	11721	DEBRIDEMENT NAIL SIX OR MORE	$45.51
Radiology	71046	CHEST X-RAY, PA & LAT	$31.28
Radiology	77067 & 77063	SCREENING MAMMOGRAPHY DIGITAL	$189.64
General Surgery	47562	LAPAROSCOPY;CHOLECYSTECTOMY-Professional Fee only, at a facility	$666.13
Optometry	92014	EYE EXAM & TREATMENT	$126.12
ASC (Ambulatory surgical center) / Endoscopy Suite	Grouper 2		$469.00
ASC Endoscopy Suite	Grouper 8		$1,104.00

** Medicare does not assign (or may not yet have assigned) relative value units (RVUs) for certain service codes. Codes not valued by Medicare are referred to as "gap codes." For example, Medicare does not assign values for wellness service codes (99381-99397). CMG refers to The Essential RBRVS (Annual) guide to obtain relative values for such gap codes for billing purposes. Typically, Cigna pays CMG for gap codes not valued by Medicare either at the discounted fee schedule referenced above or, for new codes not yet valued by Medicare, at the same rate it pays its other participating providers.*

The Urgent Care case rate excluding radiology and laboratory services is $135.

CMG pharmacy rates:

Brand Name: 30-day supply: AWP – 10.56% + $2.75 dispensing fee

90-day supply: AWP – 17.91% + $1.50 dispensing fee

Generic*: 30-day supply: AWP – 35% + $2.75 dispensing fee

90-day supply: AWP - 21% + $1.50 dispensing fee

** If MAC pricing is available for generic medication, rate is MAC + dispensing fee*