FILED 8/25/25
ENTERED 11:55 a.m.
JEFF WHIDBY, COUNTY CLERK JW

Resolution No. 9-25-39
Requested by: Benefits Director

RESOLUTION APPROVING AND AUTHORIZING THE COUNTY MAYOR TO EXECUTE THE MEDICAL AND PRESCRIPTION BENEFIT PLAN CONTRACT WITH CIGNA HEALTH AND LIFE INSURANCE COMPANY

WHEREAS, Williamson County provides group health and prescription plan insurance for County employees and officials; and

WHEREAS, Cigna Health and Life Insurance Company has administered the County's Medical and Prescription Benefit Plan for Williamson County for the past several years; and

WHEREAS, the Williamson County Purchasing agent requested proposals from interested healthcare providers to administer the County's group employee healthcare plan; and

WHEREAS, in May of 2025, after reviewing documentation concerning the responses from healthcare providers, the Purchasing and Insurance Committee selected Cigna Health and Life Insurance Company as the best responsive proposal to continue administering the County's employee healthcare and prescription benefit plan; and

WHEREAS, pursuant to Tenn. Code Ann. § 8-27-403, the Williamson County Purchasing and Insurance Committee presents the contract with Cigna Health and Life Insurance Company for approval by the Board of Commissioners:

NOW, THEREFORE, BE IT RESOLVED, that the Williamson County Board of Commissioners, meeting in regular session this the 8th day of September, 2025, in accordance with *Tenn. Code Ann. § 8-27-403,* approves the contract with Cigna Health and Life Insurance Company and authorizes the Williamson County Mayor to execute the contract and all related documentation required to administer Williamson County's group employee healthcare and prescription benefit plan.

County Commissioner

COMMITTEES REFERRED TO & ACTION TAKEN:

Purchasing & Insurance Committee	For 4	Against 1	Pass_____	Out_____
Budget Committee	For_____	Against_____	Pass_____	Out_____
Commission Action Taken:	For_____	Against_____	Pass_____	Out_____

Jeff Whidby, County Clerk

Commission Chairman

Rogers C. Anderson, Williamson County Mayor

Date

AGREEMENT
HEALTHCARE PLAN ADMINISTRATION CONTRACT

THIS AGREEMENT is entered into by and between WILLIAMSON COUNTY, TENNESSEE, a political subdivision of the State of Tennessee, located at 1320 West Main Street, Franklin, Tennessee, 37064, and CIGNA HEALTH AND LIFE INSURANCE COMPANY, which has a local office located at 1000 Corporate Centre Drive, Suite 500, Franklin, Tennessee 37067, for the provision of all services required to administer the Williamson County Employee Benefit Plan.

ARTICLE I
DEFINITIONS

A. As used in this Agreement, the following terms have the specific meaning assigned them:

1. "**Administrator**" means Cigna Health and Life Insurance Company whose local office is located at 1000 Corporate Centre Drive, Suite 500, Franklin, Tennessee 37067;
2. "**Agreement**" means the Agreement between County and Administrator as contained herein and in any attachments or exhibits to this Agreement explicitly incorporated into this Agreement by the parties;
3. "**Contract Documents**" means this Agreement, the County's request for proposal documents, the Administrator's response to the County's request for proposal and any attachments, exhibits, amendments, and clarifications provided by the County;
4. "**County**" means Williamson County, Tennessee;
5. "**ERISA**" means the Employee Retirement Income Security Act of 1974 as amended. The Administrator understands and agrees that public employers are exempt from ERISA. Any document that is provided by Administrator that includes ERISA processes or language shall not apply to the Plan, Members, or the County;
6. "**Fee**" or "**Contract Price**" means the total compensation that County shall pay to the Administrator for services required to administer the County's Plan;
7. "**Member**" means a person eligible for and enrolled in the Plan as an employee or dependent;
8. "**Participating Providers**" means the providers of health care services and products who contract directly or indirectly with Administrator to provide services and products to Members;
9. "**Party/Parties**" means the County and Administrator, each a Party and collectively referred to as Parties;
10. "**Plan Year**" means the 12 month period beginning on the Effective Date and, thereafter, each subsequent 12 month period;
11. "**Plan**" means the County adopted benefit plan titled as Williamson County Employee Benefits Plan Document and Summary Plan Description, as periodically amended;
12. "**Plan Benefits**" means the amounts payable for covered health care services and products under the terms of the Plan;
13. "**Proposal**" means the proposal submitted by Administrator and included herewith;
14. "**Run-Out Claims**" means claims for Plan Benefits relating to health care services and products that are incurred prior to termination of this Agreement or termination of a Plan benefit option, or termination of eligible members, as applicable; and
15. "**Services**" mean the provision of all labor, equipment, activities and material required to administer the Plan as required herein.

ARTICLE II
INTENT AND INTERPRETATION

With respect to the intent and interpretation of this Agreement and the Contract Documents, County and Administrator agree as follows:

1. Whenever a word, term or phrase is used in the Contract Documents, it shall be interpreted or construed first, as defined herein; second, if not defined, according to its generally accepted meaning in the healthcare industry; and third, if there is no generally accepted meaning in the healthcare industry, according to its common and customary usage;
2. The words "include", "includes" or "including", as used in this Agreement shall be deemed to be followed by the phrase, "without limitation";
3. In the event of any conflict, discrepancy or inconsistency among any of the documents which make up this Agreement and the Administrator's Proposal, this Agreement shall govern.

ARTICLE III
REPRESENTATIONS OF THE VENDOR

In order to induce County to execute this Agreement and recognizing that County is relying thereon, the Administrator, by executing this Agreement, makes the following express representations to the County:

1. It is fully qualified to act as the Administrator of the Plan and has, and shall maintain all licenses and other authorizations necessary to act as the Administrator to provide the Services requested by the County;
2. It has received, reviewed and carefully examined all of the documents and has found them to be generally sufficient to indicate and convey an understanding of the terms and conditions for the provision of Services.
3. It is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department, State Department or local department;
4. It has not, within a 3-year period preceding this Agreement, been convicted of or had a civil judgment rendered against it for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
5. It is not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of other similar crimes;
6. It has not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default; and
7. It will comply with all Federal, State, and local governmental laws, rules, and regulations relating to its responsibilities and obligations.

ARTICLE IV
CLAIM ADMINISTRATION AND SERVICES

1. County is responsible for administering Plan enrollment. In determining any person's right to benefits under the Plan, Administrator shall rely upon enrollment and eligibility information determined and provided by County. Such information shall identify the effective date of eligibility and termination date of eligibility and shall be provided to Administrator in a mutually agreed upon timeframe and format for the proper administration of the Plan. Administrator shall have no liability for administering the Plan in reliance upon enrollment and eligibility information provided by County.

2. While this Agreement is in effect, Administrator shall, consistent with the claim administration policies and procedures then applicable to its own health care insurance business and the Plan:

(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.

3. County hereby delegates to Administrator the authority, responsibility and discretion to determine coverage under the Plan based on the eligibility and enrollment information provided to Administrator by County. County also hereby delegates to Administrator the authority, responsibility and discretion to make factual determinations and to interpret the provisions of the Plan to make coverage determinations on claims for Plan Benefits, and notify the Member or the Member's authorized representative of its decision. County will ensure that all summary plan description materials provided to Members reflect this delegation of discretionary authority.

4. In addition to the basic claim administrative Services described above, Administrator shall also perform the Plan-related administrative duties agreed upon by the Parties and specified in the attached Exhibit B.

5. Following the termination of this Agreement or termination of eligibility of a Member, if the required fees have been paid in full, Administrator shall process Run-Out Claims for the applicable Run-Out Period. At the termination of any applicable Run-Out Period, Administrator shall cease processing Run-Out Claims and make all relevant records in its possession relating to such claims reasonably available to County or County's designee.

ARTICLE V
FUNDING AND PAYMENT OF CLAIMS

1. County shall establish a bank account, and maintain in the bank account an amount sufficient at all times to fund checks written on it for (i) Plan Benefits (ii) those charges and fees identified in the Schedule of Financial Charges as payable through the bank account and (iii) Plan-related charge or assessment that County is not otherwise exempt, which are imposed by any governmental authority. Bank Account Payments may include without limitation: (a) fixed per person payments and pay-for-performance payments to Participating Providers; (b) amounts County owes to Administrator for Services provided under the Plan which are not billed to County; and (c) amounts paid to Administrator's affiliates and/or subcontractors for, among other things, network access or in- and out-of network health care services/products provided to Members. Administrator shall credit the bank account with payments due County under its or an affiliate's stop loss policy.

2. In the event that sufficient funds are not available in the bank account to pay all bank account payments when due, Administrator shall immediately contact County to provide it an opportunity to deposit funds in the bank account. County shall promptly reimburse Administrator for any bank account payments paid by Administrator with its own funds on County's behalf.

3. Administrator 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 Administrator determines that it has overpaid a claim for Plan Benefits, paid Plan Benefits to the wrong party, or overpaid a pay-for-performance payment ("Overpayment"), Administrator or its affiliates shall take all reasonable steps to recover such Overpayment ("Overpayment Recovery"). Overpayment Recovery efforts for Services rendered by Participating Providers may include, subject to the terms of Participating Provider agreements, reasonable steps to wholly or partially offset any Overpayment against other payments owed to such Participating Providers for services provided under the Plan or other unrelated plans administered by Administrator or its affiliates. County also authorizes Administrator and its affiliates to recover Overpayment(s) made to Participating Providers for Services provided under other, unrelated

plans administered on behalf of County by Administrator or its affiliates by offsetting the amount of any such Overpayment(s) against Plan Benefits and/or pay-for-performance payments otherwise payable to those Participating Providers for Services provided to Members. Claims subject to Overpayment Recovery as part of any reasonable Overpayment Recovery efforts for the Plan, or Overpayment Recovery efforts for Administrator's own health care insurance business shall be selected based on factors such as the age and amount of the Overpayment. Administrator 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 County or to recover pay-for- performance overpayments (collectively "Pay-for-Performance Recoveries"). Administrator 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, Administrator is expressly authorized by County to take all actions on behalf of the County 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 Administrator shall be responsible for the attorney fees, court costs or arbitration fees incurred by Administrator 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 indirect, associated third party costs absent consent of Administrator. Administrator shall not be responsible for reimbursing any unrecovered payments of Plan Benefits or Pay-for-Performance Recoveries unless made as a result of its negligence or intentional act or omission.

4. Administrator, as agent for the County, shall make bank account payments from the bank account in the amount Administrator determines to be proper under the Plan and/or this Agreement.

ARTICLE VI
FEES

1. Administrator shall provide to County a monthly statement of all charges County is obligated to pay under this Agreement that are not paid as bank account payments. Payment of all Fees shall be due on the first day of the month as indicated on the monthly statement.

2. If an employee becomes a Member on or before the 15th day of the month, full charges applicable to that Member shall be due for that Member for that month. If coverage does not start or ceases on or before the 15th day of the month for a Member, no charges shall be due for that Member for that month.

3. Following termination of this Agreement, County shall remain liable for payment of all due bank account payments and for all reimbursements due to Members under the Plan. County shall reimburse Administrator for any bank account payments paid by Administrator with Administrator's funds and no such payment by Administrator shall be construed as an assumption of any of County's liability.

4. Unless otherwise provided herein, Administrator shall not revise the Fees identified in this Agreement without the prior written approval of County.

ARTICLE VII
CLAIM AUDITS AND CONFIDENTIALITY

1. County may, at no charge to the County, for 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 audit Administrator's payment of Plan Benefits. County shall provide Administrator a letter detailing its intent to audit all payment records in accordance with the letter and this Agreement. County may obtain the services of third party auditors to conduct the audit under the direction of the County. County shall provide the Administrator with no less than thirty (30) days advance notice of the audit. County shall be responsible for the cost of the Auditor.

2. Subject to the requirements of applicable law, the terms of this Agreement and any signed confidentiality document between Administrator and third-party conducting the audit, Administrator shall

release copies of claim and Plan Benefit payment information in Administrator's claims system. County shall maintain the confidentiality of all confidential and proprietary information confidential subject to the requirements of applicable law. Administrator shall maintain the confidentiality of all protected health information in its possession in accordance with applicable law. In the event County requests to alter the scope of the claim audit, Administrator will accommodate County's request, which may be subject to additional charges to be mutually agreed upon by County and Administrator prior to the start of the audit.

ARTICLE VIII
TERM AND TERMINATION

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

1. The date which is at least 60 days from the date that the County provides written notice to Administrator of termination of the Agreement;
2. The effective date of any applicable law or governmental action which prohibits performance of the activities required by this Agreement;
3. Any other date mutually agreed to by the Parties;
4. The provision of written notice from the County to the Administrator no less than 30 days from the annual anniversary date; or
5. The 5 year anniversary from the effective date.

ARTICLE IX
ETHICAL STANDARDS

1. It shall be a breach of ethical standards for any person to offer, give or agree to give any County employee or former County employee, or for any County employee or former County employee to solicit, demand, accept or agree to accept from another person, a gratuity or an offer of employment in connection with any decision, approval, disapproval, recommendation, preparation of any part of a program requirement or a purchase request, influencing the content of any specification or procurement standard, rendering of advice, investigation, auditing or in any other advisory capacity in any proceeding or application, request for ruling, determination, claim or controversy or other particular matter, pertaining to any program requirement or a contract or subcontract or to any solicitation or proposal therefore.
2. It shall also be a breach of ethical standards for a person to be retained, or to retain a person, to solicit or to secure a contract with County upon the agreement or understanding for a contingent commission, percentage or brokerage fee, except for the retention of bona fide employees or bona fide established commercial selling agencies for the purpose of securing business.
3. The Administrator affirms that it has not retained anyone in violation of this Article. A breach of ethical standards is a material breach of this Agreement and could result in civil or criminal sanctions and/or debarment or suspension from contracting with County.

ARTICLE X
DISPUTE RESOLUTION

The parties agree to make a reasonable effort to informally resolve, among themselves, disputes that may arise during the performance of this Agreement in a timely, professional and non-adversarial manner. Any agreements reached by the parties utilizing these informal dispute resolution procedures are not binding unless this agreement is contained in an amendment to this Agreement. County and Administrator may exercise such rights or remedies as either may otherwise have with respect to any dispute. Nothing in this provision shall create any right of either party to alternative dispute resolution, arbitration, mediation or partnering.

ARTICLE XI
INDEMNIFICATION AND HOLD HARMLESS

Administrator shall indemnify and hold harmless County, its officers, agents and employees from:

1. Any claims, damages, costs and attorney fees for injuries or damages arising, in part or in whole, from the negligent or intentional acts or omissions of Administrator, its officers, employees and/or any third party providing services on behalf of Administrator, in connection with the performance of the Agreement;
2. Any claims, damages, penalties, costs and attorney fees arising from any failure of Administrator, its officers, employees and/or agents, including third parties providing services on behalf of Administrator, to observe applicable laws including, but not limited to, copyright laws, labor laws, and minimum wage laws; and
3. Any claims, damages, penalties, costs and attorney fees arising from any action brought against County by any of Administrator's officers, employees and/or agents arising out of any injury incurred by such officer, employee and/or agent in the course of the performance of this Agreement, regardless of the cause of such injury.

County will not indemnify, defend or hold harmless in any fashion the Administrator from any claims arising from any failure, regardless of any language in any attachment or other document that the Administrator may provide.

Administrator shall pay County any expenses incurred as a result of Administrator's failure to fulfill any obligation in a professional and timely manner under this Agreement.

ARTICLE XII
INSURANCE REQUIREMENTS

Without limiting its liability under this Agreement administrator will procure and maintain at its own expense during the life of the Agreement any/all applicable insurance types and in the minimum amounts stated as follows:

1. Commercial General Liability – Must be on an Occurrence Form and will include:
   - a) Per Occurrence limit of not less than $ 1,000,000
   - b) General Aggregate will not be less than $ 2,000,000
   - c) Medical Expense Limit will not be less than $ 5,000 on any one person.
   - d) Broad-Form Contractual Liability
   - e) Personal Injury

2. Business Auto Liability (including owned, non-owned and hired vehicles)
   - a) Combined Single Limit $ 1,000,000 or
   - b) Split Limit:
     Bodily Injury: $ 1,000,000 Each Person, $ 1,000,000 Each Accident
     Property Damage: $ 1,000,000 Each Accident

3. Umbrella Excess Liability
   - a) $ 1,000,000 per occurrence and in the aggregate over primary insurance

4. Workers Compensation
   - a) State: Statutory
   - b) Employer's Liability:
     $ 1,000,000 per Accident

$ 1,000,000 Disease, Policy Limit
$ 1,000,000 Disease Each Employee

The Commercial General Liability policy will include Williamson County Government as an Additional Insured on a blanket basis with respect to the Agreement only. Said insurance will be written by a company or companies licensed to do business in the State of Tennessee and rated a minimum of A, VIII by A.M. Best Company, Inc. at the time of insurance placement or renewal, whichever is later. Before commencing any work hereunder, a Certificate of Insurance evidencing the maintenance of said insurance will be furnished to Williamson County Government Risk Management.

ARTICLE XIII
RESPONSIBLE REPORTING AGENT

Administrator shall be the Responsible Reporting Agent on behalf of County. Administrator shall be responsible for conducting all reporting requirements mandated by Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007.

ARTICLE XIV
GENERAL PROVISIONS

1. Choice of Law. The validity, construction, and effect of this Agreement and any and all extensions and/or modifications thereof shall be governed exclusively by the laws of the State of Tennessee. Tennessee law shall govern regardless of any language in any attachment or other document that the Administrator has or may provide. Any language specifying any other governing law included in this Agreement is deleted and is void.

2. Venue. Any action between the parties arising from this Agreement shall be maintained exclusively in the courts of Williamson County, Tennessee.

3. Attorney Fees. Administrator agrees that, in the event either Party deems it necessary to take legal action to enforce any provisions of this Agreement, and in the event County prevails, Administrator shall pay all expenses of such action including reasonable attorney fees and court costs at all stages of litigation.

4. Notices.

a. Delivery. Except as otherwise provided herein, any notice or other communication between the parties regarding the matters contemplated by this Agreement may be sent by United States mail (first class, airmail or express mail), commercial courier, facsimile or electronic mail, in each case delivered to the address set forth below for the recipient.

b. Receipt. Communications shall be deemed received, if by mail, on the earlier of receipt or the third calendar day after deposit in the mail with postage prepaid; if by courier, when delivered as evidenced by the courier's records; if by facsimile, upon confirmation of receipt by the sending telecopier; and if by electronic mail, when first available on the recipient's mail server. If received on a day other than a business day, or on a business day but after 4:30 p.m., recipient's local time, the communication will be deemed received at 9:00 a.m. the next business day.

c. Addresses:

i. If to County: Williamson County, Tennessee
1320 West Main Street, Suite 125
Franklin, TN 37064

ii. If to Administrator:
Cigna Health and Life Insurance Company
1000 Corporate Centre Drive, Suite 500
Franklin, TN 37067

5. Assignment. The provisions of this Agreement shall inure to the benefit of and be binding upon the respective successors and assignees of the Parties hereto. Neither Party may assign any right, interest, or obligation hereunder without the express written consent of the other Party; provided, however that Administrator may assign any right, interest, or responsibility under this Agreement to its affiliates and/or subcontract specific obligations under this Agreement provided that Administrator is not relieved of its obligations under this Agreement when doing so.

6. Third Party Beneficiaries. This Agreement is solely for the benefit of County and Administrator. It shall not be construed to create any legal relationship between Administrator and any other party or between County and any other party.

7. Limitation of Legal Avenues. County does not agree to any terms which limit its rights or opportunities to legal recourse in any way in a court of competent jurisdiction, including but not limited to,

modification of the statute of limitations or binding arbitration. To limit the legal rights of the County granted by constitution or statute may require legislation by the Williamson County Board of Commissioners and the Tennessee State Legislature.

8. Tennessee Open Records Act. Administrator understands that County is subject to the Tennessee Open Records Act and that this Act may require the County to provide requested documents to members of the public or press including, but not limited to, a copy of this contract, addendums and the Proposal. Compliance by County with the Open Records Act shall not be a breach of any Agreement. Should County receive a request to release any documents or information related to this relationship, including, but not limited to a copy of this contract, addendums and the Proposal, County agrees to inform Administrator of such request and allow Administrator to determine whether such information or documents may be released. Administrator agrees that it shall defend, at its own expense, any determination it makes with regard to the request to hold back any information from release.

9. Identifying Information. Except as agreed in writing by the parties 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 internet site.

10. Severability. Should any court of competent jurisdiction declare any provision of this Agreement invalid, then such provision shall be severed and shall not affect the validity of the remaining provisions of this Agreement.

11. Modification of Agreement. This Agreement constitutes the entire contract between the Parties regarding the subject matter herein. No modifications or amendments hereto shall be valid unless in writing and signed by an authorized person of each of the Parties.

12. Modification of Plan. County shall provide Administrator written notice of any modification or amendment to the Plan sufficiently in advance of any such change as to allow Administrator to implement the modification or amendment. County and Administrator shall agree upon the manner and timing of the implementation of such modification or amendment subject to Administrator's system and operational capabilities. County is solely responsible for communicating any Plan modification or amendment to Members or individuals considering enrolling in the Plan.

13. Employment Practices. Administrator shall not subscribe to any personnel policy which permits or allows for the promotion, demotion, employment, dismissal or laying off of any individual due to race, creed, color, national origin, age, sex or which is in violation of applicable laws concerning the employment of individuals with disabilities. Administrator, if applicable, agrees to execute the Fair Employment Affidavit included in this Agreement evidencing Administrator's compliance of this policy.

14. Employment of Illegal Immigrants. The Administrator shall not knowingly hire any unauthorized employees or fail to comply with record keeping requirements set forth in the Federal Immigration Reform and Control Act of 1986, Chapter 878 of the 2006 Tennessee Public Acts and all other applicable laws.

15. Relationship Between the Parties. The relationship of the parties shall be that of an independent contractor. No principal-agent or employer-employee relationship is created by this Agreement. The parties hereto shall not hold themselves out in a manner contrary to the terms of this paragraph. No party shall become liable for any representation, act or omission of any other party contrary to the terms of this paragraph.

16. Maintenance of Records. Administrator shall maintain documentation for all charges against County. The books, records and documents of the Administrator, insofar as they relate to work performed or money received under this Agreement, shall be maintained for a period of 3 full years from the date of final payment and will be subject to audit, at any reasonable time and upon reasonable notice, by County or its duly appointed representatives. The books and records shall be maintained in accordance with generally accepted accounting principles. For the avoidance of doubt, the use of the term audit in this Section of the Agreement, does not include claim audits as previously described in this Agreement.

17. Notification of Legal Matters. If any action is instituted against Administrator relating to this Agreement or any Services provided hereunder, or in the event Administrator becomes aware of facts or circumstances which indicate a reasonable possibility of litigation with any Member, Participating

Provider or any other third person or entity, relevant to the rights, obligations, responsibilities, or duties of the Administrator under this Agreement, such Administrator shall provide timely notice to the County.

18. Confidentiality of PHI. Administrator shall maintain the confidentiality of all Protected Health Information in its possession in accordance with all applicable laws and shall take such steps to ensure confidentiality is maintained.

19. Anti-Deficiency Clause. Nothing contained in this Agreement shall be construed as binding County to expend any sum in excess of appropriations made by its Legislative Body for the purposes of this Agreement, or as involving County in any contract or other obligation for the further expenditure of money in excess of such appropriations.

20. Conflicting Terms. The parties agree that should the language in this Agreement conflict with any language included in any documentation whether provided for by Administrator or not, then the language or terms of this Agreement shall be controlling.

21. Construction. This Agreement has been fully reviewed and negotiated by the parties hereto and their respective legal counsel. Accordingly, in interpreting this Agreement, no weight shall be placed upon which party hereto or its counsel drafted the provision being interpreted. Wherever this Agreement provides for one party hereto to provide authorization, agreement, approval or consent to another party hereto, or provides for mutual agreement of the parties hereto, such authorization, approval, agreement or consent shall, except as may otherwise be specified herein, be given in such party's reasonable judgment and reasonable discretion, and shall be in writing unless otherwise mutually agreed by the parties.

22. Headings. The headings in this Agreement are for convenience and reference and are not intended to define or limit the scope of any provisions of this Agreement.

23. Effective Date. This Agreement shall not be binding upon the Parties until it has been signed first by Administrator and then by the authorized representatives of Williamson County government and has been filed in the office of the Williamson County Mayor. When it has been so signed and filed, this Agreement shall be effective.

24. Information in Administrator's Processing Systems. Administrator may retain and use all Plan-related claim/payment information recorded/integrated into Administrator's business records (including claim processing systems) in the ordinary course of business. Such information will be available to County. Administrator will retain such Plan-related claim/payment information in accordance with its record retention policy and Applicable Law.

25. Independent Contractors. Except as explicitly set forth in this Agreement, 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 Administrator 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, Administrator is authorized to perform certain services on behalf of County under this Agreement and this provision is not intended to in any way diminish that authorization.

26. 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, Administrator 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 County other than the limited right to receive and use the services under and in accordance with this Agreement. Administrator shall own and be free to use and incorporate without payment or other consideration to County any ideas, suggestions, recommendations, or other feedback provided to Administrator 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.

27. 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.

28. Boycott of Israel. Administrator certifies that it is not currently engaged in, and will not for the duration of the Agreement engage in, a boycott of Israel as defined by Tenn. Code Ann. § 12-4-119. This provision shall not apply to contracts with a total value of less than two hundred fifty thousand dollars ($250,000) or to contractors with less than ten (10) employees.

LAST ITEM ON PAGE.
SIGNATURE PAGE TO FOLLOW

WILLIAMSON COUNTY:

CIGNA HEALTH AND LIFE INSURANCE COMPANY:

_____
County Mayor

By:_____

Title: Contract Director

Purchasing Agent:

_____

RECOMMENDED:
Department Head

_____
Department:

APPROVED AS TO AVAILABILITY OF FUNDS:

_____
Director of Finance

APPROVED AS TO INSURANCE:

_____
Department of Risk Management

APPROVED AS TO FORM AND LEGALITY:

_____
Williamson County Attorney

FILED IN THE OFFICE OF THE WILLIAMSON COUNTY MAYOR:

_____

Date:_____

Schedule of Financial Charges

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

	MEDICAL/PHARMACY ADMINISTRATION CHARGES	
Product	**Description**	**Charge**
Medical	Open Access Plus (OAP) with Care Management Preferred	**$22.05/employee/month**
Medical	HSA Open Access Plus (OAP) with Care Management Preferred (All HSA (excluding Cobra); [Benopts: HSACF, HSACI, HSAF, HSAI, HSARF, HSARI, HSRCF, HSRCI])	**$27.30/employee/month**
Medical	HSA Open Access Plus (OAP) with Care Management Preferred (ALL HSA (Cobra); [Benopts: HSCCF, HSCCI, HSCOF, HSCOI])	**$22.05/employee/month**
Medical	LocalPlus IN (LCPIN) with Care Management Preferred	**$22.05/employee/month**
Medical	HSA LocalPlus IN (LCPIN) with Care Management Preferred (All LocalPlus-In HSA (Cobra); [Benopts: LHCF1, LHCI1, LHCI2, LPHF1])	**$22.05/employee/month**
Medical	HSA LocalPlus IN (LCPIN) with Care Management Preferred (All LocalPlus-In HSA (excluding Cobra); [Benopts: LHRCF, LHRCI, LPHCF, LPHCI, LPHF, LPHI, LPHRF, LPHRI])	**$27.30/employee/month**
Pharmacy	Pharmacy-Standalone	**Included at No Additional Cost**

	MEDICAL NETWORK ACCESS FEE, UTILIZATION MANAGEMENT FEE AND OPTIONAL PROGRAM FEE	
Product	**Description**	**Charge**
Medical	OAP Access Fee	**$20.47/employee/month Included in Medical Administration Charge**
Medical	HSA OAP Access Fee (All Plans)	**$20.47/employee/month Included in Medical Administration Charge**
Medical	LCPIN Access Fee	**$20.47/employee/month Included in Medical Administration Charge**
Medical	HSA LCPIN Access Fee (All Plans)	**$20.47/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 2026 Plan Year will be 0.00% 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 0.00% over the 2026 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 Administrator may revise the above charges/fees pursuant to Section 8.a.ii, 8.a.iii and/or 8.a.iv of this Agreement.	

	CIGNA CHOICE FUND AND OTHER CONSUMER DIRECTED ACCOUNT ADMINISTRATION SERVICES AND CHARGES	
	Product	**Charge**
	Cigna Choice Fund Health Savings Account (HSA) Administration (Non-Cobra Only)	**For HSA OAP (All HSA (excluding Cobra); [Benopts: HSACF, HSACI, HSAF, HSAI, HSARF, HSARI, HSRCF, HSRCI])** **and HSA LCPIN (All LocalPlus-In HSA (excluding Cobra); [Benopts: LHRCF, LHRCI, LPHCF, LPHCI, LPHF, LPHI, LPHRF, LPHRI]) Products: $5.25/employee/month Included in Medical Administration Charge**

AMOUNTS OWED TO ADMINISTRATOR
Administrator may pay amounts with its own funds on behalf of County or the Plan for charges which County 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 Administrator shall be the County's financial responsibility. Administrator is authorized to recover all such amounts from the Bank Account.

CIGNA PHARMACY BENEFIT MANAGEMENT SERVICES CHARGES AND RELATED PROVISIONS
PHARMACY ADMINISTRATION FEE
Cigna Pharmacy Product Administration Fee, only if applicable, is separate from the Medical Administration Charge shown above, but included on same billing line as the Medical Administration Charge for billing purposes only.

FINANCIAL GUARANTEES FOR DRUGS COVERED UNDER THE PLAN'S PHARMACY BENEFIT
Covered Drugs Dispensed by Cigna Home Delivery Pharmacy: Administrator will guarantee the following charges for Covered Drugs dispensed by Cigna Home Delivery Pharmacy, subject to the provisions in the section titled "PBM Pricing – Additional Provisions":
Brand Drug Claims: For all Cigna Home Delivery Pharmacy Brand Drug Claims, the County's guaranteed annual average discount will be AWP minus 23.50%. **Generic Drug Claims:** For all Cigna Home Delivery Pharmacy Generic Drug Claims, the County's guaranteed annual average discount will be AWP minus 89.00%. **Dispensing Fees for Drug Claims:** For all Cigna Home Delivery Pharmacy Brand Drug Claims and Generic Drug Claims the County's guaranteed annual average Dispensing Fee will be $0.00.
Covered Drugs Dispensed by Retail Pharmacies in 30-day* supplies: Administrator will guarantee the following charges for Covered Drugs dispensed by Retail Pharmacies in 30-day supplies, subject to the provisions in the section titled "PBM Pricing – Additional Provisions": ***A 30-day supply means any Covered Drug dispensed by a Retail Pharmacy in an amount less than an 83-day supply.**
Brand Drug Claims: For all Retail Pharmacy Brand Drug Claims, the County's guaranteed annual average discount will be AWP minus 19.80%. **Generic Drug Claims:** For all Retail Pharmacy Generic Drug Claims, the County's guaranteed annual average discount will be AWP minus 85.00%. **Dispensing Fees for Both Brand Drug Claims and Generic Drug Claims:** For all Retail Pharmacy Brand Drug Claims and Generic Drug Claims, the County's guaranteed annual average Dispensing Fee will be $0.45.
Covered Drugs Dispensed by Retail Pharmacies in 90-day supplies:** Administrator will guarantee the following charges for Covered Drugs dispensed by Retail Pharmacies in 90-day supplies, subject to the provisions in the section titled "PBM Pricing - Additional Provisions": ****A 90-day supply means any Covered Drug dispensed by a Retail Pharmacy in an amount equal to or greater than an 83-day supply.**
Brand Drug Claims: For all Retail Pharmacy Brand Drug Claims, the County's guaranteed annual average discount will be AWP minus 23.50%. **Generic Drug Claims:** For all Retail Pharmacy Generic Drug Claims, the County's guaranteed annual average discount will be AWP minus 87.00%. **Dispensing Fees for Both Brand Drug Claims and Generic Drug Claims:** For all Retail Pharmacy Brand Drug Claims and Generic Drug Claims, the County's guaranteed annual average Dispensing Fee will be $0.00.

AGGREGATE SPECIALTY DRUG DISCOUNT GUARANTEE
Administrator shall guarantee an aggregate annual average ingredient cost discount of AWP minus 22.00% for covered Specialty Drug prescriptions dispensed by Retail Pharmacies and Cigna Home Delivery Pharmacy. Administrator's performance will be measured based on analysis of Plan-specific utilization for the applicable contract year.

EnReachRx℠ Pharmacy Program
(EnReachRx Program Pricing is Effective as of January 1, 2026, unless County has Opted Out of the Program)

The EnReachRx℠ Pharmacy Program is a Member support clinical program for certain, designated medications. The pricing for Covered Drugs dispensed under the EnReachRx℠ Program is stated below. Claims dispensed under the EnReachRx℠ Program will be excluded from the pharmacy pricing set forth above. Claims dispensed by the EnGuide Pharmacy℠ as part of dose optimization will be deemed a Retail 30 Claim for Rebate reconciliation purposes, as applicable.

	EnReachRx℠ Retail Pharmacies	EnGuide Pharmacy℠
Ingredient Cost	Lesser of U&C or AWP – 19.75%	AWP – 20.00%
Dispensing and Shipping Fee†	$0.00	$10.00
Professional Service Fee	$25.00	$25.00

†Shipping Fees are inclusive of shipping and handling. If carrier rates (i.e., U.S. mail and/or applicable commercial courier services) increase during the term of this Agreement, the Shipping Fee will be increased to reflect such increase(s).

RECONCILIATION OF PHARMACY BENEFIT MANAGEMENT FINANCIAL GUARANTEES
Pricing Guarantee Calculation. The following calculation will be performed on an aggregated basis for all paid Claims for Covered Drugs processed during the applicable contract year in order to reconcile against the average annual ingredient cost discount guarantees set forth above: 1 – [(the total ingredient cost charged to the County prior to application of the Plan's Member cost-share requirements)/ (the total AWP) for all Covered Drugs] For the purposes of the pricing guarantee calculation, and notwithstanding anything herein to the contrary, the total ingredient cost shall also include the ingredient cost for a Covered Drug for which a Member pays 100% in the form of cost-share. The application of brand and generic pricing may be subject to certain "dispensed as written" ("DAW") protocols and County defined plan design and coverage policies for adjudication and Member Copayment purposes. For example, DAW 5 (House Generic) claims will be considered a Generic Drug claim for pricing purposes.

Pricing Guarantee Exclusions. The following Claims or products shall be excluded from the calculation of any pricing guarantee set forth in this Agreement:

- Specialty Drugs, unless otherwise noted in this Schedule of Financial Charges.
- Workers' Compensation Claims.
- Claims for Supplies.
- Non-standard facility Claims (Indian Tribal facilities).
- Non-standard facility Claims (Military facilities).
- Non-standard facility Claims (Veterans Administration).
- Limited Distribution Drugs and Exclusive Distribution Drugs.
- Subrogation Claims.
- Repackaged products.
- Products filled through Pharmacies not participating in the network accessed by County under this Agreement (including a contracted pharmacy that does not participate in a sub-network or preferred network tier).
- Over-the-counter (OTC) products.
- Secondary Payer Claims.
- Direct Member Reimbursement Claims.
- Compound Drugs.
- Claim reversals.
- Outlier Claims (Brand Drug Claims with an AWP discount of >95% and AWP price >$10,000).
- 340B Claims.
- Claims for Covered Drugs paid at the Retail Pharmacy's U&C Charge or Submitted Cash Price shall be included in the calculation of any Retail Pharmacy pricing guarantee set forth in this Agreement.
- Claims where pharmacy reimbursement is determined or mandated by Applicable Law, not based on Administrator's contracted rates with the Retail Pharmacy (applicable to Retail dispensing fee guarantees only).

RECONCILIATION AND OFFSETS REGARDING FINANCIAL GUARANTEES

Administrator will report on the guaranteed amounts within one-hundred eighty (180) days following the end of each contract year. Upon reconciliation, Administrator's performance with respect to each ingredient cost discount or Dispensing Fee guarantee offered under this Agreement will be individually measured and then reconciled in the aggregate across all ingredient cost discount or Dispensing Fee guarantees.

PBM PRICING – ADDITIONAL PROVISIONS
• For a specific Claim for a Covered Drug dispensed by a Retail Pharmacy or Cigna Home Delivery Pharmacy, and after application of any Plan cost-share requirements, Administrator shall charge the County the lowest of the following amounts: (1) The Prescription Drug Charge; or (2) The pharmacy's submitted U&C Charge, if any.
• For a specific Claim for a Covered Drug dispensed by a Retail Pharmacy or Cigna Home Delivery Pharmacy, Administrator shall charge the Member in accordance with the terms of the Pharmacy Benefit. For example, for a Covered Drug subject to a fixed dollar copayment requirement, Administrator shall charge the Member the lowest of the following amounts: (1) The fixed dollar copayment for the Covered Drug, if any; (2) The Prescription Drug Charge; and (3) The pharmacy's submitted U&C Charge, if any.
• Administrator may apply, if available and based on price favorability to the Member, a discount card market price for certain non-specialty drug generic products (unless County opts out of program enrollment).
• Home Delivery Pharmacy Dispensing Fees and Dispensing Fee Guarantees are inclusive of shipping and handling. If carrier rates (i.e., U.S. mail and/or applicable commercial courier services) increase during the term of this Agreement, the Home Delivery Pharmacy Dispensing Fee and Home Delivery Pharmacy Dispensing Fee Guarantee will be increased to reflect such increase(s).
• Any pricing guarantees, including any ingredient cost discount or Dispensing Fee guarantee, set forth in this Agreement shall be rendered null and void in the event County terminates Administrator's administration of the Pharmacy Benefit prior to completion of the then-current Plan Year.
• Administrator's fees, Rebates (if any), discounts or guarantees (if any) are, among other conditions communicated in this Agreement or otherwise in writing to County, contingent on, and assume, adoption by County of a specific Formulary, Retail Pharmacy network, and Plan design features (e.g., cost-share structure, utilization/cost management programs).
• For purposes of all pharmacy ingredient cost discount and Dispensing Fee guarantees and exclusions, only those Specialty Drugs on the Specialty Financial Guarantee Drug List shall be deemed and treated as a Specialty Drug. Specialty Drugs not appearing on the Specialty Financial Guarantee Drug List shall be deemed and treated as a non-specialty drug for ingredient cost discount and Dispensing Fee

guarantee and exclusion purposes. The Specialty Financial Guarantee Drug List is subject to change by Administrator at its discretion and available upon request.

- Notwithstanding any other provision of this Agreement, Administrator may, effective upon written notice to County, adjust any or all of the fees, Rebates (if any), discounts or guarantees (if any) in this Agreement to the extent reasonably necessary to preserve the economic value of this Agreement to Administrator as it existed immediately prior to any of the following events or changes: (a) there are any significant changes in the composition of the Administrator pharmacy network utilized by County hereunder or in such pharmacy network's contract compensation rates, or the structure of the pharmacy stores/chains/vendors that are contracted with Administrator, including but not limited to disruption in the retail pharmacy delivery model, or bankruptcy of a chain pharmacy; or there is a change in or to the pharmacy network reflected in the pharmacy pricing summary; or (b) there is a change in government laws or regulations which has a significant impact on pharmacy claim costs; or (c) any material manufacturer-rebate contracts with, or for the benefit of, Administrator are terminated or modified in whole or in part or unexpected product offering decisions by drug manufacturers that result in an unexpected introduction of a lower cost alternative product that may replace an existing rebatable brand product; an un expected launch of a generic product; or a branded product unexpectedly converted to OTC status, recalled or withdrawn from the market; or (d) there is any legal action or law that materially affects, or could materially affect the manner in which Administrator's rebate program is administered or an existing law is interpreted so as to materially affect or potentially have a material effect, on Administrator's administration of the Plan; (e) a major change in market conditions affecting the pharmaceutical or pharmacy benefit management market, a drug shortage in the market, an issue involving the safety of the drug supply, an unexpected introduction of a new drug, including a new Generic Drug or Biosimilar Drug, or similar market event occurs; (f) the Pharmacy Benefit enrollment decreases by equal to or greater than ten percent (10%) from the enrollment on which Administrator's financial offer is based; or (g) County fails to disclose a material feature of the Plan or the Plan's Pharmacy Benefit or there is a change to the Plan's Pharmacy Benefit including but not limited to the Formulary, benefit designs, OTC plans, clinical or trend programs or otherwise that has the effect of lowering the amount of Rebates earned hereunder or materially impacting any guarantee. The financial terms provided herein are based on Administrator's underwriting assumptions; pricing is subject to adjustment for a material change in these assumptions.

DRUG MANUFACTURER-PAYMENT SHARING

Subject to the caveats below, Administrator will remit to County the following portion of Rebates and Manufacturer Administrative Fees that Administrator collects with respect to utilization of Covered Drugs under the Plan's Pharmacy Benefit:

For All Products:

The greater of: (1) 100.00% of Rebates and Manufacturer Administrative Fees on such utilization dispensed in the full calendar year immediately preceding Administrator's remittance; (2) or the sum of $400.00 multiplied by the number of Retail Pharmacy Brand Drug Claims (excluding Specialty Brand Drug Claims) dispensed in 30-day* supplies plus $1,010.00 multiplied by the number of Retail Pharmacy Brand Drug Claims (excluding Specialty Brand Drug Claims) dispensed in 90-day** supplies plus $1,170.00 multiplied by the number of Cigna Home Delivery Pharmacy Brand Drug Claims (excluding Specialty Brand Drug Claims) plus $3,815.00 multiplied by the number of Retail Pharmacy

Specialty Brand Drug Claims plus $3,815.00 multiplied by the number of Cigna Home Delivery Pharmacy Specialty Brand Drug Claims processed in such full calendar year.

Caveats:

(1) Administrator or its agents contract with drug manufacturers on Administrator's own behalf, and not on behalf of or as agent of the County or the Plan. Rebates are paid based on the contractual terms set forth in this Agreement.

(2) Should County terminate this Agreement before completion of the then-current Plan Year, no Rebates shall be due and owing with respect to that Plan Year, and any Rebate minimum or fixed dollar guarantees shall be null and void, as the payment of Rebates is conditioned on Administrator exclusively administering the Pharmacy Benefits for the entire Plan Year.

(3) For percentage-based sharing arrangements, Rebate payout amounts may differ slightly from the stated percentage when payout occurs before manufacturers' final reconciliations and payments are made to Administrator. For purposes of clarity, Administrator shall reconcile its performance with respect to any Rebate payment guarantees, including, without limitation, any minimum or fixed dollar guarantees, in the aggregate. Moreover, any amount directly or indirectly provided by a manufacturer or other third party that is allocated to reduce and/or wholly or partially satisfy a Member's cost-sharing obligation for a Covered Drug under the Patient Assurance Program shall be included for purposes of reconciling Administrator's performance against any Rebate minimum guarantee set forth in this Agreement.

(4) For percentage-based sharing arrangements, the percentage share payment of Rebates shall not include the payment of any Rebates received, if any, for Run-Out Claims, 340b Claims, Medical Specialty Claims, Direct Member Reimbursement Claims, Reversed Claims, and Compound Claims.

(5) Administrator may use Rebates otherwise payable to County to offset payable Bank Account Payments or other payable fees or charges identified in this Agreement.

(6) County acknowledges that it may be eligible for Rebate amounts and Manufacturer Administrative Fee amounts under this Agreement only so long as County, its affiliates, or its agents do not contract directly or indirectly with any of person or entity for discounts, utilization limits, rebates or other financial incentives on pharmaceutical products or formulary programs for Claims processed by Administrator pursuant to this Agreement, without the prior written consent of Administrator. In the event that County negotiates or arranges for Rebates or similar discounts for any Covered Drugs hereunder, but without limiting Administrator's right to other remedies, Administrator may immediately withhold any Rebate amounts or Manufacturer Administrative Fee amounts earned but not yet paid to County. To the extent County knowingly negotiates and/or contracts for discounts or rebates on Claims for Covered Drugs without prior written approval of Administrator, such activity will be deemed to be a material breach of this Agreement, entitling Administrator to suspend payment of Rebate amounts and Manufacturer Administrative Fee amounts hereunder and to renegotiate the terms and conditions of this Agreement.

(7) Rebate and Manufacturer Administrative Fee amounts paid to County pursuant to this Agreement are intended to be treated as "discounts" pursuant to the federal anti-kickback statute set forth at 42 U.S.C. §1320a-7b and implementing regulations. County is obligated if requested by the Secretary of the United States Department of Health and Human Services, or as otherwise required by Applicable Law, to report the Rebate amounts and to provide a copy of this notice. Administrator will refrain from doing anything that would impede County from meeting any such obligation.

(8) The Rebate payment commitments, including any minimum or fixed dollar guarantees, if any, set forth in this Schedule of Financial Charges are, among any other conditions communicated in this Agreement or otherwise in writing to County, contingent on the availability of Rebates to Administrator and County's Pharmacy Benefit applying a 90-day supply limit for Specialty Drugs. and standard days' supply limits. In the event that County has adopted, or adopts, a 30-day supply limit for Specialty Drugs, or participates in the Clinical Day Supply Program, Administrator may revise on an equitable basis the stated Rebate minimum or fixed dollar guarantees, if any, to the extent necessary to reflect Administrator's revised estimate of Rebates it may collect on a plan design having adopted a days' supply limit for Specialty Drug of less than 90 days or the Clinical Day Supply Program.

(9) Notwithstanding anything to the contrary, to the extent, if any, there is a Rebate guarantee set forth in this Agreement, Rebate guarantee calculations, reconciliations, and payments shall be net of the decrease in Rebates caused by market events resulting from a change in Law.

(10) Biologic Rebate Credit. Notwithstanding anything to the contrary, to the extent, if any, there is a Rebate guarantee set forth in this Agreement, Rebate guarantee calculations, reconciliations, and payments may be reduced by a Rebate Credit. "Rebate Credit" shall mean the aggregate difference between (i) the Rebate applied to the Reference Product and (ii) the Rebate applied to the Low List Price Biologic Product; provided, however, that if the Reference Product exits the market, ceases contracting, or is, or becomes, non-formulary, the Rebate for the Standard List Price for the Biologic Product will apply in subsection (i) above in lieu of the Rebate for the Reference Product in subsection (i) above. For purposes of this provision, the term "Reference Product" shall mean a biological product as defined in the Biologics Price Competition and Innovation Act at 42 U.S.C. §262(i)(4) and approved under Section 51(k) of the Public Health Services Act. For purposes of this provision, the term "Low List Price Biologic Product" shall mean a Biologic Product with a wholesale acquisition cost that: (i) has decreased by at least 25%; or (ii) is at least 25% less than the Reference Product, or the Standard List Price for the Biologic Product, if applicable. For purposes of this provision, the term "Standard List Price for the Biologic Product" shall mean a Biologic Product with a wholesale acquisition cost that is comparable to the wholesale acquisition cost of the Reference Product. For purposes of this provision, the term "Biologic Product" shall mean a biological product as defined in the Biologics Price Competition and Innovation Act of 2009 at 42 U.S.C. §262(i)(1) and (2) and approved under Section 351(k) of the Public Health Services Act.

(11) For Rebate guarantee and exclusion purposes, only those Specialty Drugs on the Specialty Financial Guarantee Drug List shall be deemed and treated as a Specialty Drug. Specialty Drugs not appearing on the Specialty Financial Guarantee Drug List shall be deemed

and treated as a non-specialty drug for Rebate guarantee and exclusion purposes. The Specialty Financial Guarantee Drug List is subject to change by Administrator at its discretion and available upon request.

Timing of Rebate Pay-Out: Remittance will be provided within ninety (90) days after the close of each applicable calendar quarter for the portion of such calendar quarter that coincides with the Plan Year.

REBATE PAYMENT EXCLUSIONS

The Rebate Guarantee payment obligations set forth in this Schedule of Financial Charges shall exclude the following types of claims and/or products:

- Claims paid pursuant to a Dispense as Written (DAW) 5 code.
- Direct Member Reimbursement Claims.
- Repackaged products.
- Brand Drug Claims paid at a MAC.
- Non-standard facility Claims (Indian Tribal facilities).
- Non-standard facility Claims (Military facilities).
- Non-standard facility Claims (Veterans Administration).
- Pharmaceutical supplies other than diabetic test strips.
- Vaccines.
- Compound Drugs.
- Claim reversals.
- 340B Claims.
- Run-Out Claims.
- Non-Formulary Drug Claims.

PHARMACY VACCINE PROGRAM

Notwithstanding anything to the contrary in this Agreement or otherwise, the following terms and conditions shall apply to the administration of vaccines by Administrator under the Cigna Pharmacy Program.

Vaccine Claims will adjudicate at the lower of the U&C Charge or the amounts shown in the Vaccine Pricing Schedule below. For Vaccine Claims, the U&C Charge shall be the retail price charged by an in-network participating retail pharmacy for the particular vaccine, including administration and dispensing fees, in a cash transaction on the date the vaccine is dispensed as reported to Administrator by the in-network participating pharmacy.

"Vaccine Claim" means a claim for a Covered Drug which is a vaccine.

Notwithstanding anything to the contrary in this Agreement or otherwise, all Vaccine Claims shall be excluded from the calculation, measurement, and payment of any and all financial guarantees, including but not limited to rebate guarantees, ingredient cost guarantees, and dispensing fee guarantees set forth in this Agreement.

Administrator reserves the right to revise and modify the Vaccine Pricing Schedule below, including but not limited to revising or adding an additional Pharmacy Vaccine Administration Fee or Vaccine Program Fee, based on changing market dynamics, the entrant of new vaccines, or changes in law or interpretation of law.

Vaccine Pricing Schedule

* To the extent, if any, County's Schedule of Financial Charges includes a Pharmacy Administrative Fee charged on a per prescription basis, then such fee shall apply for Vaccine Claims.

	Retail Pharmacy INFLUENZA	**Retail Pharmacy COVID**	**Retail Pharmacy ALL OTHER VACCINES**	**Member Submitted Vaccine Claims**
Pharmacy Vaccine Administration Fee	Pass-Through (Capped at $20 per in-network Vaccine Claim)	Pass-Through (capped at $40 per in-network Vaccine Claim)	Pass-Through (capped at $25 per in-network Vaccine Claim)	Submitted amount
Ingredient Cost	Retail Pharmacy Ingredient Cost as set forth in this Agreement	Retail Pharmacy Ingredient Cost as set forth in this Agreement	Retail Pharmacy Ingredient Cost as set forth in this Agreement	Submitted amount
Dispensing Fee	Retail Pharmacy Dispensing Fee as set forth in this Agreement	Retail Pharmacy Dispensing Fee as set forth in this Agreement	Retail Pharmacy Dispensing Fee as set forth in this Agreement	Submitted amount
Vaccine Program Fee	$2.50 Vaccine claim			N/A

CIGNA HOME DELIVERY PHARMACY DISCLOSURE		
	Product	**Charge**
Cigna Home Delivery Pharmacy (a Administrator affiliated company(ies))	Medical 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 Administrator 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 contracts 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 Administrator offers to entities like County 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 Administrator in connection with Administrator 's services hereunder. This provision shall survive termination or expiration of the Agreement.	**Medical specialty drug's charge under a national specialty drug discount schedule that generates a 20.50% annual average aggregate discount off AWP across medical specialty drug claims dispensed at Cigna Home Delivery Pharmacy to Administrator 's self-funded and insured group-client book of business.**
FEES FOR PROCESSING RUN-OUT CLAIMS		
OAP, HSA OAP, LCPIN and HSA LCPIN	Run-Out Period of twelve (12) months Administrator shall not be required to process Run-Out Claims until it has received full payment of the required fees.	**The sum of the last four (4) months of billed fees applicable to the terminated (i) Agreement, (ii) Plan benefit option or (iii) Member eligibility.**
Pharmacy	Run-Out Period of three (3) months for all pharmacy claims	**No Additional Cost**

ADMINISTRATOR MEDICAL OUT-OF-NETWORK PROTECTION PROGRAM FEES

County agrees that Administrator will use the programs listed in this section (the "**Out-of-Network Protection Programs**" or "OON Protection Programs") to contain costs with respect to charges for health care services and/or supplies that are covered by the Plan, as set forth in the applicable Plan Booklet. These services and/or supplies may include, but are not limited to, claims received from non-Participating Providers and claims that are subject to the federal No Surprises Act and are not otherwise subject to state law ("NSA Services"). OON Protection Programs may also apply to covered services and/or supplies received from providers that are not included in certain specialized or narrow networks but who are otherwise Participating Providers in Administrator's broader networks (for example, OAP Participating Providers that are not included in specialized networks designed for gene therapy or advanced cell therapy, or that are not in the LocalPlus network). Administrator may contract with vendors to provide or perform various services related to the OON Protection Programs.

Administrator's per claim charges for administering the OON Protection Programs ("OON Protection Program Charges") are identified in the table below and are calculated based on a percentage of the Gross Savings achieved on each claim, i.e., the difference between the charge the provider made or would have made, and the allowable amount achieved by the OON Protection Programs. Administrator will make OON Protection Program Charges to the Bank Account. OON Protection Program Charges will appear in reports available to County, including County's Bank Account activity data reports. OON Protection Program Charges shall not exceed $30,000 per claim (the "Per Claim Cap").

If applicable, Administrator, or a vendor retained by Administrator, may participate in negotiation or independent dispute resolution processes arising under: (i) state laws addressing reimbursement of non-Participating Providers or; (ii) the federal No Surprises Act, resulting in payments that are not based on the OON Protection Programs. If additional payment is owed as a result of these negotiations or independent dispute resolution processes, Administrator, as agent for the County, shall make a charge to the Bank Account in the amount of such additional payment.

The administration of the OON Protection Programs is consistent with the claim administration practices with respect to Administrator 's own health care insurance business, unless otherwise required by law.

1. OON Protection Programs for Services/Supplies that are not NSA Services

OON Protection Programs seek a reduction of providers' charges to allowable amounts that Administrator, in its discretion, determines are market competitive ("Discounts"). Discounts may be determined on a claim-by-claim basis before or after services are rendered.

In many cases, applying Discounts may substantially reduce the total cost of the claim and/or the patient's out-of-pocket cost and avoid the patient being balance-billed for amounts the Plan does not cover, but may result in payments higher than the County's applicable (a) Plan-/policyholder-selected percentile of provider charges for the same or similar service or supply in the geographic area based on a database selected by Administrator, or (b) Plan-/policyholder-elected percentage of a fee schedule that Administrator has developed based on a methodology similar to a methodology used by Medicare to determine the allowable reimbursement for the same or similar service within the geographic market.

If no Discount is applied through OON Protection Programs, allowable amounts will be based on the Maximum Reimbursable Charge as calculated without a Discount, unless required otherwise by law. Allowable amounts that are not based on the OON Protection Programs, may result in the patient being balance-billed for the entire unreimbursed amount. Applying the Discounts may avoid balance billing and substantially reduce the cost of the claim and/or the patient's out-of-pocket cost.

2. OON Protection Programs for NSA Services

For NSA Services, Administrator will issue initial payments at amounts determined by Administrator 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 recognized amount or qualifying payment amount (QPA), as calculated by Administrator. Patient cost-share will be based on the lower of the QPA, the non-Participating Provider's billed charges, the Initial Allowed Amount, or the amount determined by Administrator to be required by state law (if applicable).

Patients cannot be balance-billed for amounts the Plan does not cover. Patient cost-share will not increase as a result of negotiations or independent dispute resolution determinations under the No Surprises Act.

3. OON Protection Program Charges

1.	Network Savings Program *Provides access to a network of providers that are contracted through a third party to provide care at a discounted rate. The customer's ID Card must include an icon displaying the third party's network logo to be eligible for any available Discounts. Administrator does not guarantee that the available Discount will be applied to every eligible claim and application will depend on the level of Discount available.*	**35% of Gross savings**
2.	Bill Negotiation Services Programs	
	• *Supplemental Network* *Provides access to networks of providers that are contracted through a third party to provide care at a discounted rate. The customer's ID card need not include any third party network logo to be eligible for any available Discounts. Administrator does not guarantee that the available Discount will be applied to every eligible claim..*	**35% of Gross savings**
	• *Professional Fee Negotiation, including Single Case Agreements* *Administrator, or a vendor retained by Administrator, negotiates an agreement with the provider that establishes the amount at which the provider agrees to accept as payment in full*	**35% of Gross savings**

	• *Re-pricing* *Administrator, or a vendor retained by Administrator, determines the allowed amount based on a rate deemed to be market competitive, and the provider subsequently does not bill and/or obligate the patient the difference between the charged amount and the allowed amount.*	**35% of Gross savings**
3.	State or Federal Compliance Pricing *Calculation and application of the recognized amount or QPA for NSA Services, and negotiation or independent dispute resolution under the federal No Surprises Act or state regulation, where payment is not based on the Network Savings Program or Bill Negotiation Services Programs. There are no additional fees charged to the County for handling the negotiation or independent dispute resolution process arising under state law or the federal No Surprises Act.*	**35% of Gross savings**
4.	Independent Dispute Resolution Administration Fee under the federal No Surprises Act *Per dispute administration fee when a provider files a dispute. The Administration Fee is subject to change per any adjustments made by applicable law, rule, or regulation.*	**$115 Administration Fee per dispute**
5.	Independent Dispute Resolution Entity Fee under the federal No Surprises Act *Per dispute arbitration entity fee when a provider files a dispute.*	**$450 Entity Fee per dispute**

ADMINISTRATOR MEDICAL PAYMENT INTEGRITY PROGRAM FEES

Administrator administers the programs listed below to contain costs with respect to charges for non-Participating and Participating medical health care service/supplies that are covered by the Plan (the "**Payment Integrity Programs**"). In administering these Payment Integrity Programs, Administrator may contract with vendors to perform various tasks related to the Payment Integrity Programs.

Administrator's charge for administering the Payment Integrity Program is the applicable percentage indicated in the table below of the:

1 "Gross Savings" (i.e., the difference between the originally calculated allowable amount and the amount paid to the provider as a result of the Payment Integrity Program); and

2 "Gross Recovery" (i.e., the amount recovered as a result of the Payment Integrity Program).

Administrator will make a per claim charge to the Bank Account that includes both Administrator's applicable Payment Integrity Program charge, as shown in the table below, and the applicable vendor charge. Administrator will pay the vendor its charge. Payment Integrity Program charges will appear in County's Bank Account activity data reports.

1.	Bill Review, Clinical coding validation and editing (Pre- and Post-payment) Includes: • Hospital Bill Review (Inpatient/Outpatient) • Medical Implant Device Review (Inpatient/Outpatient) • Clinical Waste and Abuse Claim Review (Facility & Professional) • High-Cost Specialty Pharmaceutical Review • Other Target Billing Accuracy Programs	**If there is savings or recovery, any fees or expenses passed through by the hospital or regulatory agency, plus 29% of the gross savings/gross recovery**
2.	Diagnosis Related Grouping (DRG) Review (Pre- and Post-payment) to ensure coding is consistent with care rendered and coding standards.	**If there is savings or recovery, any fees or expenses passed through by the hospital or regulatory agency, plus 29% of the gross savings/gross recovery**
3.	Coordination of Benefits (COB) Investigation and Recoveries to identify if Member has other insurance. Includes Medicare and other commercial health coverage.	**29% of the gross recovery**
4.	Secondary Vendor Recovery Program. Specialized vendor partners run proprietary queries to determine the reasonableness, appropriateness, accuracy, and applicability of select claim payments	**29% of the gross recovery**
5.	Provider Credit Balance Recovery Program. Audit/reconciliation of facility accounts which are in a negative balance, due to incorrect billing or payment made to a provider.	**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.	**29% of the gross recovery**
7.	Subrogation/Conditional Claim Payment. Identification, investigation, and recovery of claim payments involving other party liability or where another entity is responsible for payment	**29% of the gross recovery if no counsel is retained and in all other**

	(including by way of example but not by limitation automobile insurance, homeowner insurance, commercial property insurance, worker's compensation).	**instances, including cases where state law requires that employee benefit plans be named as party defendants or involuntary plaintiffs.** **Litigation costs if counsel is retained and an appearance is filed on behalf of Administrator or County in any litigation, or a lawsuit is filed on their behalf, plus 5% of the gross recovery.**
8.	Medical Cost Class Action Recoveries. Administrator identifies, monitors, and may (but is not required to) participate, on behalf of County, as a plaintiff in class action lawsuits or similar legal proceedings against third parties whose actions entitle County to recover damages for medical costs it paid as Plan Benefits (e.g. medical device product liability class actions, mass tort recovery class actions, etc.), including, without limitation, lawsuits alleging legal or equitable claims like product liability, fraud, anti-trust violations, or unfair trade practices. As part of this authority, Administrator may participate in a settlement, exclude County from a settlement and/or otherwise represent County's interests outside the settlement. Administrator collects and retains a percentage any recovery (net of attorneys' fees) attributable to County's Plan as compensation for these services.	**35% of the gross recovery**
ADMINISTRATOR PHARMACY COST CONTAINMENT FEES		
Administrator 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, Administrator contracts with vendors or a Administrator affiliate to perform program related services.		

Administrator 's charge for administering these programs may be a percentage (indicated below) of the "recovery" (i.e. the amount recovered) as applicable.		
Class Action Recoveries	Administrator identifies, monitors, and may (but is not required to) participate, on behalf of County, in class action lawsuits or similar legal proceedings against pharmaceutical manufacturers, including, without limitation, lawsuits alleging legal or equitable claims like fraud, anti-trust violations, or unfair trade practices by a manufacturer. As part of this authority, Administrator may participate in a settlement, exclude County from a settlement and/or otherwise represent County's interests outside the settlement. Administrator collects and retains as a recovery fee set forth herein of any recovery (net of attorneys' fees) attributable to County's Plan.	**35.00% of recovery**
Pharmacy Recoveries	Administrator performs regular, ongoing review of 100% of Retail Pharmacy claims through desk audit and field audit based on a predictive model in order to determine the accuracy of payments for 100% of Retail Pharmacy claims. In the event that it is discovered that an overpayment has been made to a Retail Pharmacy, Administrator shall take reasonable steps to recover and return 100% of the overpayment pursuant to the terms of this Agreement.	**Included at no Additional Cost**
SaveOnSP Program	A Member cost share savings program available when the County makes plan design changes to certain, designated covered prescription drugs as non-essential health benefits and establishes Member cost share at amounts that allow for receipt of manufacturer-supported patient cost share assistance. The program fee shall be measured and calculated based on the program's standard savings methodology. Payment of program fees shall be charged to the Bank Account and invoiced on a monthly, incurred basis. Additional terms and conditions of the SaveOnSP program are set forth in the attached SaveOnSP Appendix C.	**25.00% of program savings plus any applicable tertiary cost share**
EMBARC BENEFIT PROTECTION® A NETWORK SOLUTION FOR CERTAIN HIGH-COST GENE THERAPY DRUGS		
Embarc Benefit Protection	To provide financial protection from the high cost of certain gene therapy drugs, Administrator 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 gene therapy drugs listed on Cigna.com and Evernorth.com for Members when the indicated drugs are covered by the Plan administered by Administrator, and medically necessary (as determined by Administrator). Gene therapy drugs are continually being evaluated and may be added to the network solution after FDA approval. The complete list of included drugs and any associated contractual limitations can be found at both Cigna.com and Evernorth.com.	**$1.25 per Member/per month** If, across eviCore's entire Embarc Benefit Protection book of business (Cigna and non-Cigna clients), eviCore's cost for

	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 Administrator 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 County's monthly reporting. Embarc Benefit Protection does not provide financial protection from the cost of administering these drugs. These costs are small in comparison to the drug costs. When covered under the Plan and determined by Administrator to be medically necessary for the treatment of the specified conditions, Members will not incur any out-of-pocket costs for the drugs and the Plan will not be required to reimburse any expenses for the drugs with the following exceptions: <u>Exceptions</u>: 1. Members with an HSA must have met the applicable minimum deductible required for a high deductible health plan. 2. As otherwise stated on Cigna.com or Evernorth.com **eviCore's Embarc Benefit Protection and PMPM charge do not apply to a plan that:** i. does not cover all drugs included in Embarc Benefit Protection; ii. covers any of the drugs exclusively under its pharmacy benefits which are not administered by Administrator, or iii. does not utilize an eviCore participating provider.	the covered 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, for both active and terminated clients, after having fully recovered the outstanding balance created by any prior year deficits. The refund, if 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-

	Upon County's request on or after the Effective Date, Administrator shall provide to County an updated drug list, if applicable. Administrator may revise charges/fees by giving County at least thirty (30) days' prior written notice.	business information for that calendar year.
ADVANCED CELLULAR THERAPY PROGRAM		
Advanced Cellular Therapy Program	The Advanced Cellular Therapy Program (ACT) is an enhanced network benefit solution designed to manage the high cost of advanced cellular therapies (e.g. CAR T-cell therapy). This program delivers predictability, clinically appropriate care and maximizes affordability by leveraging a specially selected provider network, with benefit language that includes a travel benefit and a dedicated care management team to support Participating Members receiving these therapies. For all in-network medical claims covered under the ACT Program at an existing ACT participating provider, County shall pay Administrator (who in turn will pay the rendering ACT participating provider) a Guaranteed Price for the covered advanced cellular therapy. The Guaranteed Price shall equal the Average Wholesale Price (AWP) of the covered advanced cellular therapy minus 10% and will be charged to the Bank Account. Guaranteed Price for the covered advanced cellular therapy (ACT) | AWP minus 10% County understands and agrees that the amount paid by Administrator for the therapy may or may not be equal to the Guaranteed Price charged to County and Administrator will absorb or retain any difference. There are related costs for Participating Members receiving these therapies that will be paid as covered services according to the Plan.	
CARE MANAGEMENT/COST CONTAINMENT PROGRAM FEES		
	Administrator 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 Administrator, and/or (ii) improve adherence to evidence based guidelines designed to promote patient safety and efficient patient care.	**Applicable third-party fees and care management program services are listed below, and additional**

	Unless otherwise specified in this Schedule of Financial Charges, charges for these services will be processed through the Bank Account.	**details 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.**
	In addition to such third parties, Administrator has arranged for an affiliate, eviCore, to provide the following care management/cost-containment programs:	
	Pre-certification of coverage of radiation therapy services.	**$958.00 per episode of care (EOC)** **Effective January 1, 2026: $987.00 per episode of care (EOC)**
	Pre-certification of coverage of diagnostic cardiology services.	**$0.19 PMPM**
	Pre-certification of coverage of medical oncology services.	**$1,136.00 per episode of care (EOC)** **Effective January 1, 2026: $1,170.00 per episode of care (EOC)**
	Oncology Consult Service. Medical oncology cases submitted for prior authorization will be subject to additional review against certain clinical criteria, including the appropriate setting of	**$4,250.00 per completed**

	care/service, to determine if the case would benefit from a physician-to-physician consult focused on the accuracy of the diagnosis and the optimal treatment plan. eviCore will engage a third party to facilitate the consultation, which will occur only upon acceptance by physician and the consent of the Participant.	**consultation** **(Billed directly to County)**
	Pre-certification of coverage of musculoskeletal therapy services.	**$0.42 PMPM** **Effective January 1, 2026:** **$0.43 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. 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.	**$0.12 PMPM**
	Pre-certification of coverage for appropriate setting of care/service for high-tech radiology services	**$0.17 PMPM**
	Pre-certification of coverage for appropriate setting of care/service for certain medical oncology drugs (redirection may be to Accredo, a Administrator 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: Administrator may retain a portion of the shared savings fee before reimbursing eviCore.
	Pre-certification of coverage of sleep management services.	**$0.13 PMPM**
	Network management and care coordination of coverage of home health, durable medical equipment and home infusion services.	**$0.32 PMPM**
	Administrator may revise charges/fees by giving County 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 Per Review**
STRATEGIC ALLIANCES		
	Administrator 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 Administrator's monthly charges, as a result of the application of their discounts.	**All Medical Products**

OTHER VENDORS AND HEALTH CARE SERVICES PROVIDERS		
	The fixed per person per period and/or fee-for-service charges that Administrator 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. Administratorwill charge a fee equal to a percent of performance-based payments, which will be added to these payments to support incremental costs associated with administering the programs. Additional reporting available upon request. 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 Administrator 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: • 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.	**All Products**

	• 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. Administrator'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 Administrator affiliates, and the form of payment that they currently receive.	
	NOTICE REGARDING PAYMENTS FROM THIRD PARTIES	
Rebate and Other Remuneration Disclosure (Pharmacy)	Administrator or its affiliates may contract with pharmaceutical manufacturers or other third parties for Rebates, Manufacturer Administrative Fees, and other remuneration on its or their own behalf and for its and their own benefit, and not on behalf of County or the Plan. Accordingly, unless otherwise specified in this Schedule of Financial Charges, Administrator and its affiliates retain all right, title and interest to any and all actual Rebates, Manufacturer Administrative Fees, and other remuneration received from manufacturers or other third parties; Administrator will pay County amounts equal to the Rebates, Manufacturer Administrative Fees and other remuneration, as specified above, from Administrator's general assets (neither County, its Members, nor County's Plan retains any beneficial or proprietary interest in Administrator's general assets). County acknowledges and agrees that neither it, its Members, nor its Plan will have a right to interest on, or the time value of, any Rebates, or Manufacturer Administrative Fees or other remuneration received by Administrator during the collection period or moneys payable under this Agreement. Rebates, Manufacturer Fees and other	**All Pharmacy Products**

	remuneration are paid based on the contractual terms set forth in this Agreement. As an example of the remuneration other than Rebates or Manufacturer Administrative Fees that Administrator or its affiliates may earn, Administrator or its affiliates may also directly or indirectly earn from pharmaceutical manufacturers remuneration in connection with value payments and/or services that Administrator provides to County ("Value-Based Payments"). Notwithstanding anything in this Agreement to the contrary, any Value-Based Payments earned by Administrator or its affiliates are separate and apart from any Rebates or Manufacturer Administrative Fees that Administrator or its affiliates directly or indirectly earn from pharmaceutical manufacturers, and Administrator and its affiliates may retain any Value-Based Payments it earns. As examples of the value payments and/or services that Administrator may provide to County in connection with Value-Based Payments that Administrator or its affiliates may earn, Administrator may provide care management or related services to County and/or remit to County monetary credits if Members discontinue therapy on certain pharmaceutical products. Information regarding any services, and/or monetary credits or other financial value, for which County may be eligible with respect to specific pharmaceutical products or therapeutic classes/conditions, including the products for which monetary credits or other financial value may be available to County, the amount of that value, and other payment terms, is available upon request. Any value payments and/or services provided by Administrator to County are subject to change or termination by Administrator as the value program(s), if any, offered by Administrator change(s) or terminate(s). Information on the projected aggregate amount of such Rebates with respect to the Plan Pharmacy Benefit will be provided upon request. This provision shall survive termination or expiration of the Agreement.	
Rebate and Other Remuneration Disclosure (Medical)	Administrator 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 County's Plan medical benefit. These payments may include rebates, service fees (e.g. administrative fees), or other remuneration. Administrator 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 County or the Plan. Accordingly, Administrator retains all right, title and interest to any and all such remuneration received from manufacturer; neither County, its Members, nor County's Plan retains any beneficial or proprietary interest in any such remuneration, which shall be considered part of the general assets of Administrator.	**All Medical Products**

	This provision shall survive termination or expiration of the Agreement.	
Implementation/Referral Fee Disclosure	From time to time, Administrator, 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. Administrator and its affiliates may receive payments from such third parties to help defray Administrator'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 Administrator. Administrator may also receive compensation from third-party vendors that County may retain based upon a referral from Administrator or that Members may utilize following an introduction facilitated by Administrator or an affiliate. Administrator 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**
SBC COMPLIANCE ASSISTANCE		
	Administrator shall provide the following services to assist County 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 notices. Administrator will not be responsible for any changes that County makes to the SBC.	**No charge**
2.	Provide SBC, translation notices prepared by Administrator to County 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 County or carve-out vendor provides Administrator with necessary carve-out benefit information at least twelve (12) weeks prior to the date the SBCs are to be delivered to County.	**$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 OAP,** **HSA OAP,** **LCPIN** **and HSA LCPIN 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.	**For HSA OAP** **and HSA LCPIN Products: Included in Medical Access Fee**

	• Answering health and medical related questions. • Counseling Participants on prevention and the benefits of compliance with prescribed medications and treatments.	
Comprehensive Maternity Program	Cigna Healthy Pregnancies, Healthy Babies™ program is a comprehensive maternity management program. The goal of the program is to reduce the number of pre-term and underweight babies by promoting a healthy pregnancy. Expectant mothers can enroll using either the Cigna Pregnancy App (no additional cost for both Apple and Android platforms), or call to speak with a HPHB team member over the phone. The program delivers education and telephonic support to pregnant women through the post-partum period. Nurses answer medical related questions and make suggestions for behavior changes and medical interventions aimed at improving the health of the mother and baby. Program support also covers preconception and infertility. Financial incentives may be awarded to women at the completion of this self-referral program based on the trimester enrolled. Incentives Elected:	
	Option 3 (Low): $150 – 1st Trimester/$ 75 – 2nd Trimester	**For OAP,** **HSA OAP,** **LCPIN** **and HSA LCPIN Products: Included in Medical Access Fee**
Pharmacy Clinical Program(s)	**inMynd** - is a clinically-based Member and provider comprehensive behavioral health program that includes regular retrospective review of pharmacy and medical claim data to identify certain "at risk" (i.e., members with complex psychiatric conditions using multiple psychotropic medications) member utilization patterns to help both members and providers better recognize, treat and support mental and behavioral health conditions. **Integrated Opioid Management** – Administrator's Integrated Opioid Management program is a clinically based program that uses integrated data and predictive analytics to identify Members who may benefit from the program, including first-time opioid users. The program	**Included at No Additional Cost**

	offers counseling and other alternative means through the Plan's pharmacy benefit using clinically based provider programs, and Administrator behavioral experts to support interventions with identified Members.	
Pharmacy Utilization Management Program	**Essential Package** - a utilization management program under which some pharmaceutical products are subject to one or several coverage limitations, including prior authorization, step therapy and/or quantity limits. Under a prior authorization requirement, the requested drug is generally reviewed for clinical appropriateness based on the intended use in therapy. Under a step therapy requirement, the Member generally must try one or more preferred products, or demonstrate why trying the preferred product(s) would be clinically inappropriate, in order to obtain coverage for the requested drug.	**Included in Pharmacy Administration Fee**
Pharmacy Direct Member Reimbursement	The manual processing of pharmacy claims paid by the Member at the point of sale and submitted by a Member for reimbursement claim.	**$5.00 per claim** **Charges are processed through the Bank Account.**
Specialty Medication Support	A targeted condition medication therapy management program in which Administrator 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 assisted with any questions they may have around medication side effects, given explanation around their Plan benefits, informed of the importance of adherence, assisted with the prior authorization renewal coordination, and assisted with referrals to Administrator Integrated Pharmacy Solutions clinicians and referrals to other Cigna coaching programs. Administrator acts as the primary point of contact for Members enrolled in specialty condition counseling and works to ensure that Member needs are coordinated and referred appropriately. Administrator conducts standardized assessments of Members to identify potential clinical issues and works in conjunction with nurses, pharmacists, and other parties to resolve. For the sake of clarity, if a specialty pharmacy affiliate of Administrator 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 Administrator; Administrator does not exert direction or control over the pharmacists at any specialty pharmacy affiliate.	**Included at No Additional Cost**
SafeGuardRx Program	A medication therapy management and cost containment program for select therapeutic conditions such as but not limited to oncology, inflammatory conditions, and multiple sclerosis and select drugs within therapeutic categories. This program seeks to help reduce drug therapy costs through its program offerings. For example, employers may qualify for the payment of discontinuation drug therapy credits and/or the reimbursement of drug therapy through drug	**Included at No Additional Cost**

	cost caps, on select medications and therapeutic conditions. This program may also provide for Member outreach or counseling on select medications. Administrator reserves the right to revise, modify, or terminate this program, in whole or in part, at any time. Additional and specific program information is available upon request.	

Your Health First	A proactive health education and improvement program for Members with a chronic dcondition. 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 OAP,** **HSA OAP,** **LCPIN** **and HSA LCPIN 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 Administrator'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 County's annual elections. Reward types include: HRA and Healthy Awards Account fund deposits, debit and/or gift cards, and County self-administered awards such as HSA fund deposits, healthcare premium adjustment and payroll deposit.	
	Engage Package - includes administration of County selected Administrator standard Incentives Program which provides Participating Members with County's pre-determined rewards. Activity to trigger incentives may include, but is not limited to, participation in the following available programs: Personal Health Analysis (Administrator's health assessment), Wellness Screening (biometric), Online Health Coaching, Pre-Diabetes Digital Coaching, Self-Reported Activities, Steerage (Cigna Home Delivery, Cigna Care Designation, Cigna's	**For OAP,** **HSA OAP,** **LCPIN**

	Center of Excellence facility steerage), Health Coaching by Phone, Case Management, Preventive Care (claim verified), County specific programs and Achieve Health Goals (biometric outcomes).	**and HSA LCPIN Products: Included in Medical Administration Charge**
Transparency in Coverage and Consolidated Appropriations Act, 2021	Administrator 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, Administrator 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, Administrator 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**

Health Improvement Fund		
Health Improvement Fund	For clinical/wellness/behavioral programs offered by Administrator that are purchased, Administrator will establish a Health Improvement Fund in the amount of $273,000.00. This fund will be used to defray the cost of Administrator designated and arranged health and wellness improvement programs (e.g. biometric screenings, flu shots) for Employees of County and to reward participation in these programs. The Health Improvement Fund is a one-time credit to be used from July 1, 2025-June 30, 2026. Unused funds cannot be rolled over and Administrator 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 County for the purpose of funding the cost of those reimbursable services provided prior to such notice of 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 County to Administrator for its use in administering the Plan including denials and appeals of denials of claims for Plan Benefits. If County has not provided Administrator with a copy of its finalized Plan Booklet by the time the Agreement is effective, Administrator will administer the Plan in accordance with the Plan Benefits described in the Plan Booklet draft provided by Administrator to County and Article IV of the Agreement. Administrator will continue to administer the Plan in this manner until Administrator receives the finalized Plan Booklet and follows Administrator's preparation and review process. After that time Administrator will administer the Plan in accordance with Plan Benefits described in the finalized Plan Booklet and Article IV of the Agreement.

Exhibit B – Services

BANKING AND ADMINISTRATION Excluding **Health Savings Account**		
	Furnishing Administrator's standard Bank Account activity data reports to County as and when agreed upon. Administrator's administration of the Plan does not include performing obligations, if any, under state escheat or unclaimed property laws. It is County's responsibility to determine the extent to which these laws may apply to the Plan and to comply with such laws.	**All Products**
	If County 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 surcharge on claims and assessment on covered lives directly to the New York Public Goods Pool as set forth in section 63 and has consented to the conditions set forth in section 63, Administrator shall file such forms and pay such surcharge and assessment on covered lives on behalf of County through the Bank Account to the extent set forth in section 63. For employers with Dental or Dental and Pharmacy coverage only, Administrator shall file such forms and pay such surcharge but not assessments 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 County's failure to provide any information required by Administrator to fulfill this obligation, the failure to comply with any requirement imposed upon County pursuant to the Act or the failure of County to sufficiently fund the Bank Account. In addition, where permitted and agreed to by Administrator, Administrator will file applicable forms and pay on behalf of County and/or the Plan any assessment, surcharge, tax or other similar charge which is required to be made by County 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 Administrator. Administrator's obligation to pay on behalf of County shall end immediately upon County's failure to sufficiently fund the Bank Account.	**All Products**

CLAIM ADMINISTRATION		
Excluding Health Savings Account		
	Calculate benefits, check and/or electronic payments disbursed from the Bank Account. Bank Account payments will appear in County's standard Bank Account activity data reports.	**All Products**
	Administrator's generic claim forms are made available to County and eligible individuals.	**All Products**
	Administrator'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 Administrator's book of business internal audits of plan benefit payments on a random sample basis.	**All Products (excluding Pharmacy)**
	Claim control procedures reported annually in Service Organization Controls (SOC) 1 Reports issued in accordance with American Institute of Certified Public Accountants Statement on Standards for Attestation Engagements (AICPA SSAE) No. 18 Report (or any applicable successor thereto).	**All Products (excluding Vision)**
	Respond to Insurance Department complaints.	**All Products**
	Designated toll-free telephone line for Member and Provider calls to Administrator 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 County and/or its authorized agent.	**All Products**
Medical Only		
	Administrator's enrollment methods are made available to County for enrolling individuals into the Plan.	**All Medical Products**
	Administrator's standard ID card with toll-free telephone number are prepared for Members.	**All Medical Products**
	Administration of subrogation/conditional Claim Payment (terms described in Exhibit E).	**All Medical Products**

HEALTH SAVINGS ACCOUNT		
Administration		
	Provision of Health Savings Account: Administrator shall provide to County enrollment materials for Health Savings Accounts ("**HSA**") at a bank or other authorized entity with which Administrator contracts (the "Bank Vendor") for County's Employees enrolled in an eligible High Deductible Health Plan ("**HDHP**"). Administrator and/or the Bank Vendor shall provide to County's eligible Employees who open an HSA ("**HSA Account Holder**") telephonic and Internet customer service, debit cards, HSA checks (option made available to HSA account holders from the bank) to access HSA funds, required IRS forms such as the 1099 and 5498 and access to Individual Summary Statements that reflect account activity. Administrator shall provide to County its standard reports of aggregate non-identifiable information concerning the administration of the HSA.	**HSA Product**
	Claim Forwarding: Each HSA Account Holder may elect to have claims not payable under the HDHP paid from funds in the Account Holder's HSA, to the extent that funds are available in such account ("**Claim Forwarding**"), whether or not the expense is a qualified IRS medical expense. Claim Forwarding is only available for payments due medical providers. Claim Forwarding is not available for pharmacy expenses.	**HSA Product**
	Use of HSA: HSA Account Holders are solely responsible to use HSA funds as permitted by law, including Section 223(a) of the Internal Revenue Code, to qualify for applicable tax benefits.	**HSA Product**
	Enrollment in High Deductible Health Plan - County acknowledges that its prompt furnishing of complete and accurate HDHP eligibility and benefit information, including prompt depositing of contributions, is essential to the timely and efficient administration of its Employees' health savings accounts and impacts bank ability to respond to Employee account withdrawals or payments. It is understood that Employee HDHP coverage terminations, including default terminations whether or not caused by County failure to reconcile Employee eligibility when so requested by Administrator, could result in health savings account tax consequences for the employee and/or in interrupting the Employee's eligibility to make health savings account contributions.	**HSA Product**
	Access Codes. County shall ensure that each authorized user establishes an Access Code for access to the Online Portal. County shall further ensure that authorized users safeguard all Access Codes and shall be responsible for all use of Access Codes.	**HSA Product**
	Online Portal. Access to the Online Employer Portal delivered by the Bank Vendor shall be in accordance with such manuals, training materials, terms of use, administrative control procedures, terms and conditions, and other information as shall be provided to County from time to time and County shall ensure access to Online Employer Portal complies with any such information and	**HSA Product**

	materials. County's authorized users may be assigned different levels of access. Some of the functions that County may access on the Portal are: 1) view reserve funding account balance and activity; 2) perform manual funding of Employee bank accounts; 3) download various reports; 4) learn of upcoming changes in HSA rules; 5) use the links and tools for HSA education and additional information.	
	County agrees that any access, transaction, or business conducted using the Online Employer Portal is presumed by Administrator to have been in compliance with HSA Plan Administration under Section 223(a) of the Internal Revenue Code. Any unauthorized use of the Online Employer Portal or any Access Code shall be solely the responsibility of the County.	**HSA Product**
	County Responsibilities	
	HSA Contributions - County will facilitate pre-tax payroll contributions by HSA Account Holders. County may elect to make its own contributions to HSA. County shall send HSA Account Holder contributions plus any County contributions directly to the Bank Vendor.	**HSA Product**
	Eligibility and Enrollment - County is responsible for distributing to eligible Employees the HSA enrollment application and documents provided to County by Administrator and the Bank Vendor. County will submit completed HSA enrollment applications to Administrator and/or Bank Vendor, as indicated, in the established timeframe. It is understood and agreed that an eligible Employee's HSA cannot be opened until the Bank Vendor has received all necessary documents and information and has determined the HSA can be established.	**HSA Product**
	Information Verification - County shall verify information provided to Administrator and Bank Vendor that is necessary for the establishment of the HSA. It is understood that the Bank Vendor shall rely on such information and verification in establishing and maintaining the HSA and in reporting required by law.	**HSA Product**
	Bank Vendor Relationship	
	Employee Agreement with Bank – Eligible Employees wishing to enroll in an HSA may be required to execute certain bank documents including a custodial agreement. Approved eligible Employees will become Account Holders and contract directly with the Bank Vendor for the establishment and maintenance of the HSA, including the issuance of debit cards and checks.	**HSA Product**
	Investment of Account Funds – While Bank Vendor offers various investment options in connection with the funds in the HSA, the HSA Account Holder is solely responsible for selecting and approving the investment vehicles into which their HSA funds will be invested. HSA Account Holders exercise sole investment discretion over their HSA investments.	**HSA Product**
	Bank Fees – Administrator pays Bank Vendor to administer the HSA Accounts.	**HSA Product**

	Bank Fees to Accountholder – It is understood that there are separate account fees charged each HSA Account Holder by the Bank Vendor pursuant to terms communicated to HSA Account Holders through separate bank documents.	**HSA Product**
	Confidentiality – It is understood that the confidentiality of employee information provided directly by the Employee or County (on Employee's behalf) to the Bank Vendor is governed by the terms and provisions of the agreement between the employee and the Bank Vendor, and neither the Employee nor County shall have any recourse against Administrator for any breach thereof. To the extent that County, in satisfying its obligations under this Agreement, is required to provide confidential information to Administrator, it is understood that the terms of the Agreement will apply. Administrator will ensure that confidential information will be securely handled and maintained in accordance with all Applicable Laws and/or regulations.	**HSA Product**
	Termination	
	Termination of HSA Account Holder's HDHP or of Services Under This Exhibit – Free Agents: In the event of the termination of an HSA Account Holder's HDHP coverage through Administrator, the HSA Account Holder becomes a "**Free Agent**". Similarly, should Administrator's HSA services under this Exhibit be terminated for any reason, either for a specific Employee, or for the County as a whole, the affected HSA Account Holders shall from that point on be Free Agents. For Free Agents: (1) Administrator shall no longer provide HSA services; (2) Any terms of this Exhibit shall no longer be applicable; (3) HSA shall continue to be maintained by the Bank Vendor directly not in its role as a contractor to Administrator; (4) Bank Vendor shall issue new account numbers, debit cards, checks etc. to Free Agents; and (5) Bank Vendor shall inform Free Agents of the new applicable schedule of bank fees. Even if HSA Account Holders continue HDHP coverage through COBRA, they are still considered Free Agents for purposes of HSA services hereunder.	**HSA Product**
	Retroactive Terminations: It is understood and agreed that although this ASO Agreement contemplates instances in which an Employee's HDHP coverage may be retroactively terminated, there will be no retroactive terminations with respect to HSA services provided hereunder. Termination of an Employee's HDHP coverage or termination of an HSA shall result in the termination of services rendered under this Exhibit and the applicable fees, effective as of the end of the month that Administrator receives notice of such termination.	**HSA Product**

Effect of HSA Plan on ASO Agreement Terms		
	All applicable provisions of the ASO Agreement apply to the HSA Services described in this Exhibit. In the event of a conflict between any provision of the ASO Agreement and the terms of the Exhibit with respect to the HSA services, the terms of this Exhibit shall govern.	**HSA Product**
PLAN BOOKLET		
	Prepare and make accessible Member benefit booklet drafts to County.	**All Products**
UNDERWRITING SERVICES		
	5500 Schedule C reporting.	**All Products**
	5500 Schedule A or Annual Reconciliation Disclosure reporting (when applicable)	**All Products**
	Administrator's standard Underwriting services: a) benefit design analysis b) projected cost analysis.	**All Products**
COST CONTAINMENT		
	Administrator'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**
	Medical Cost Containment, as described in the Schedule of Financial Charges.	**All Medical Products**
	Annual reporting of Administrator's standard cost containment results upon County's request.	**All Medical Products**
	Pharmacy Cost Containment, as described in the Schedule of Financial Charges.	**All Pharmacy 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 and Pharmacy Products**
	Administrator's standard pharmacy utilization reports.	**Pharmacy Product Only**
	Claim Reporting: Administrator will provide standard banking and financial report information based upon paid claim data. Administrator 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 and Pharmacy Products**
	Upon request from the County, 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	**All Medical Products**

	Administrator. Administrator 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 County have executed Administrator's standard Non-Disclosure/Data Sharing Authorization Agreements. Aggregate Stop Loss Reporting is not provided as part of the standard reporting package as employers can access claim and banking reports necessary to support aggregate stop loss administration via Cigna's web site, CignaforEmployers.com. Administrator will not provide 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. Administrator does not allow stop loss carriers to audit Administrator's claims administration under the medical benefit plan, however, the County'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 County's stop loss policy will not be available for stop loss policy administration, County is responsible for verifying any such required information with its stop loss carrier.	
	Administrator's standard Individual Summary Statements for applicable participating Members.	**HSA Products**
MEMBER EXTERNAL REVIEW PROGRAM		
	Administrator 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 Administrator on a random basis. If County has chosen not to participate in this program, the County may be responsible for making other arrangements to meet the Patient Protection and Affordable Care Act (PPACA) external review requirements.	**All Medical and Pharmacy Products**
MEDICAL MANAGEMENT SERVICES		
	Administrator 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 Administrator'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 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® provides access to solid organ and bone marrow/stem cell transplantation while improving cost containment and reducing risk. There are over five hundred sixty (560) designated transplant programs in this network. These designated programs provide transplant services at facilities which must meet or exceed the Cigna LifeSOURCE Transplant Network® performance guidelines for quality and cost criteria inclusion. Based on County's Plan design, the Cigna LifeSOURCE Transplant Network® may or may not include supplement programs as listed in Cigna LifeSOURCE.com.	**All Medical Products Except Cigna SureFit, Comprehensive, Indemnity, Network, Network OA, Network POS, and Network POSOA**
	A health education program that delivers mailings to Members with certain conditions.	**All Medical Products**
	Behavioral health services are provided/arranged by a Administrator affiliate (details available upon request), including utilization review and case management for both inpatient and outpatient, in-network behavioral health services.	**OAP,** **HSA OAP,** **LCPIN** **and HSA LCPIN 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 Administrator's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products with Care Management Preferred**
	NETWORK MANAGEMENT SERVICES	
	Administrator, 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, Administrator 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. Where Administrator has contracted with an affiliate for the provision of services by certain health care providers, amounts paid for claims under this arrangement may include amounts to reimburse Administrator's affiliate for its services, and the amounts paid for claims to the affiliate may be different than the amount paid to the rendering provider. Administrator and/or its affiliates may retain or absorb any such difference;	**All Medical Products**
	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, Administrator 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 Pharmacy Products**

	Credential and re-credential Participating Providers in accordance with Administrator's credentialing requirements and ensure that third-party network vendors credential/re-credential Participating Providers in accordance with Administrator's requirements;	**All Medical and Pharmacy Products**
	Monitor Participating Provider compliance with protocols and procedures for quality, Member satisfaction, and grievance resolution;	**All Medical and Pharmacy Products**
	Facilitate the identification of Participating Providers by Members; and	**All Medical and Pharmacy Products**
	Designated toll-free telephone line for Member and Provider calls to Administrator Service Centers.	**All Medical and Pharmacy Products**
	Access to virtual on-demand urgent care, scheduled primary care, and scheduled behavioral health visits via phone or video, and virtual dermatology visits via secure messaging. Members may access this service via myCigna.com or the myCigna app.	**All Medical Products**
	BEHAVIORAL HEALTH	
	Administrator 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 County'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 program and a cognitive behavioral modification program, InMynd pharmacy program, and an Integrated Opioid Management pharmacy 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. Administrator is paid by the affiliate for administrative services related to this program. 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, a cognitive behavioral modification program, InMynd pharmacy program, and Integrated Opioid Management pharmacy program) will be paid from the Bank Account as claims and will appear in County's monthly reporting.	**These services are included in the following products:** **OAP,** **HSA OAP,** **LCPIN** **and HSA LCPIN Products**
	EVERNORTH CARE GROUP SERVICES	
	The Cigna HealthCare of Arizona, Inc. staff model Evernorth Care Group (formerly known as Cigna Medical Group or "CMG") is a multispecialty participating provider group located in metropolitan Phoenix, Arizona. Cigna Healthcare of Arizona, Inc. and Evernorth Care Group are affiliates of Administrator. Evernorth Care Group's integrated care delivery model and population	**All Medical Products**

	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 an Evernorth Care Group 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 through the Evernorth Care Group system. For covered services provided to Participants, Evernorth Care Group 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 available upon request. 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 an Evernorth Care Group PCP. Evernorth Care Group has established collaborative referral relationships with specialty and ancillary providers in Cigna's participating provider networks, which includes affiliated entities. Evernorth Care Group 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 Evernorth Care Group 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.	

Appendix A – Pharmacy Benefit Management Services

PHARMACY BENEFIT MANAGEMENT - DEFINITIONS

Definitions

Any capitalized term not defined below shall have the meaning given to such term in the Agreement. Any capitalized term utilized in the Schedule of Financial Charges or Exhibit B shall have the meaning given to such term in the Agreement, including the meanings set forth below.

- "340B Claim" means (i) Claims submitted by 340B contracted pharmacies that adjudicate at a 340B price or are submitted with a submission clarification code of "20" or such equivalent codes for such participating network Pharmacies under the applicable NCPDP format (or any successor format); (ii) Claims identified as a 340B Claim by a third party administrator; or (iii) Claims identified as a 340B Claim by a pharmaceutical manufacturer and in which Administrator may reduce a subsequent Rebate payment (or Rebate reconciliation payment, if applicable) to account for any previously-paid Rebate amounts attributable to such claim.

- "Actuarially Estimated" shall mean that the discount(s) listed in the Schedule of Financial Charges are estimated, but not guaranteed, to result in a particular average discount for Covered Drugs administered by Administrator under this Agreement. Actuarially estimated discounts are calculated based on evaluation of an expected distribution of drug utilization across Administrator's aggregate group client book of business. As measured in the aggregate for County's Pharmacy Benefit, County's average discount results may vary based on the Plan-specific factors such as drug mix utilization.

- "Authorized Generic" shall mean a pharmaceutical product sold, licensed, or marketed under a new drug application (NDA) approved by the Food and Drug Administration (FDA) under section 505(c) of the Federal Food, Drug and Cosmetic Act (FFDCA) that is marketed, sold or distributed under a different labeler code, product code, trade name, trademark, or packaging (other than repackaging the listed drug for use in institutions) than the innovator brand name drug.

- "Average Wholesale Price" or "AWP" shall mean the average wholesale price of a Covered Drug as established and reported by Medi-Span. The applied AWP of a Covered Drug shall be the AWP for the actual eleven (11) digit National Drug Code ("NDC"), Covered Drug specific, quantity appropriate actual package size (or the manufacturer-packaged quantity closest to the dispensed size), submitted by a Retail Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy at the time that the Covered Drug is adjudicated. Notwithstanding any other provision in this Agreement, in the event of any major change in market conditions affecting the pharmaceutical or pharmacy benefit management market, including, for example, any change in the markup, methodologies, processes or algorithms underlying the published AWP(s), Administrator may adjust any or all of the Rebates, charges, rates, discounts, guarantees and/or fees in connection with Administrator's administration of the Pharmacy Benefit hereunder, including any that are based on AWP, as it reasonably deems necessary to preserve the economic value or benefit of this Agreement to Administrator as it existed immediately prior to such change. Additionally, and notwithstanding any other provision in this Agreement, Administrator may replace AWP as its pharmaceutical pricing benchmark with an alternative benchmark and/or may replace Medi-Span, or other such publication, as its source for the AWP or alternative benchmark with a different pricing source, provided that Administrator adjusts any or all such AWP-based charges or such alternative

benchmark-based charges as it reasonably deems necessary to preserve the economic value or benefit of this Agreement to Administrator as it existed immediately prior to such replacement or immediately prior to the event(s) giving rise to such replacement, as the case may be.

- "Biosimilar " shall mean a "biosimilar" biological product as defined in the Biologics Price Competition and Innovation Act of 2009 at 42 U.S.C. §262(i)(2) and approved under Section 351(k) of the Public Health Services Act.
- "Brand Drug" shall mean a prescription drug identified as such in Administrator's master drug file using indicators from First Databank (or other source nationally recognized in the prescription drug industry) on the basis of a standard Brand/Generic Algorithm, a copy of which may be made available for review by County or its auditor upon request at the time of audit. Except if and where the language expressly states otherwise, a Brand Drug does not include a Specialty Brand Drug for ingredient cost discou nt purposes.
- "Brand /Generic Algorithm" or "BGA" shall mean the standard and proprietary brand/generic algorithm, a copy of which may be made available for review by County or its auditor upon request at the time of audit. The purposes of the algorithm are to stabilize products "flipping" between brand and generic status and to reduce County, Member and provider confusion due to fluctuations in brand/generic status. County or its auditor may audit Administrator's application of its BGA to confirm that Administrator is making brand and generic drug determinations consistent with such algorithm.
- "Cigna Home Delivery Pharmacy" shall mean a duly licensed pharmacy operated by Administrator or its affiliates, where prescriptions are filled and delivered via the mail service, which may include, for example, Accredo Health Group, Inc., ESI Mail Pharmacy Service, Inc., Express Scripts Pharmacy Inc., Express Scripts Specialty Distribution Services, Inc. and Lynnfield Drug, Inc. (dba Freedom Fertility Pharmacy) but excludes the EnGuide Pharmacy.
- "Claim," for purposes of this Appendix A, is a claim or request for coverage under the Pharmacy Benefit.
- "Compound Drug" shall mean a medication that (a) is comprised of two or more gaseous, solid, semi-solid, or liquid ingredients (other than water or flavoring added to any preparation) that are weighed or measured at a pharmacy and then prepared according to the prescriber's order and the pharmacist's art; (b) contains at least one FDA-approved federal legend drug as an active ingredient; (c) is not otherwise generally available in its compound form; and (d) is not a compound preparation administered by infusion or injecti on.
- "Covered Drugs" shall mean those prescription drugs, supplies, and other items that are covered by the Plan under the Pharmacy Benefit.
- "Dispensing Fee" means an amount paid to a pharmacy for providing professional services necessary to dispense a Covered Drug to a Member.

- "EnGuide Pharmacy" means a duly licensed pharmacy operated by Administrator or its affiliates, where prescriptions are filled and delivered via the mail service under the EnReachRx Program.
- "FDA" shall mean the U.S. Food and Drug Administration.
- "Formulary" shall mean the list of FDA-approved prescription drugs and supplies developed and managed by Administrator for its self-funded book of business and that is selected and adopted by County. The drugs and supplies included on the Formulary will be modified by Administrator from time to time as a result of factors including, but not limited to, economic and clinical factors like clinical appropriateness, manufacturer Rebate arrangements and patent expirations. Any changes Administrator makes to the Formulary are hereby adopted by County, subject to County's discretion to elect not to implement any such addition or deletion through the set-up process, any such election shall be considered an County change to the Formulary.
- "Generic Drug" shall mean a prescription drug, whether identified by its chemical, proprietary, or non-proprietary name, that is therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient(s) and approved by the FDA, and which is identified as such in Administrator's master drug file using indicators from First Databank (or other source nationally recognized in the prescription drug industry) on the basis of a standard Brand/Generic Algorithm, a copy of which may be made available for review by County or its auditor upon request at the time of audit. For pricing purposes, a Generic Drug excludes a Covered Drug that is either marketed under one (1) Abbreviated New Drug Application pursuant to 21 U.S.C. §355, and its implementing regulations, or cannot be purchased by the pharmaceutical industry at large from more than one (1) pharmaceutical wholesaler. For pricing purposes, a Generic Drug also excludes a Biosimilar.
- "Limited Distribution Drug" or "Exclusive Distribution Drug" shall mean a Specialty Drug that is not generally available from most or all pharmacies but is restricted to select pharmacies as determined by a pharmaceutical manufacturer. The list of Limited Distribution Drugs and Exclusive Distribution Drugs will be maintained by Administrator.
- "Maximum Allowable Charge" shall mean the maximum unit price for a Covered Drug included on the applicable MAC List as set forth on such MAC List.
- "MAC List" shall mean a then-current list maintained by Administrator of prescription drugs, devices, supplies and over-the-counter drugs identified as readily available as a Generic Drug or generally equivalent to a Brand Drug (in which case it may also be on a MAC List) and that, in each case, are deemed to require or are otherwise capable of pricing management due to the number of manufacturers, utilization and/or pricing volatility.
- "Manufacturer Administrative Fees" shall mean administrative fees paid by pharmaceutical manufacturers and recieved by Administrator directly in connection with administering, invoicing, allocating and collecting Rebates.

- 'Participating Pharmacy" means any licensed retail pharmacy with which Administrator or one or more of its affiliates has executed an agreement to provide Covered Drugs to Members, but shall not include any mail order or specialty pharmacy affiliated with any such Participating Pharmacy. Participating Pharmacies are independent contractors of Administrator of its affiliates.

- "Pharmacy Benefits" shall mean amounts payable for covered pharmacy benefit services and products under the terms of the Plan; Pharmacy Benefits shall be considered Plan Benefits for purposes of this Agreement.

- "P&T Committee" shall mean a committee comprised of clinicians that represent a range of clinical specialties. The committee regularly reviews pharmaceutical products, new pharmaceutical products, for safety and efficacy, the findings of which clinical reviews inform coverage status decisions made by Administrator. The P&T Committee's review may be based on consideration of, without limitation, FDA-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

- "PBM Proprietary Information" shall mean information relating to Administrator's pharmacy benefit management products and services, including, without limitation, Administrator's reporting and web-based applications, eligibility and adjudication systems and coding methodologies, system formats and databanks, clinical or formulary management operations or programs, information and agreements relating to Rebates and other financial information, prescription drug evaluation criteria and coverage policies, drug pricing information, including MAC List and Specialty Drug pricing, paid Claims information integrated into Administrator's adjudication systems, and pharmaceutical manufacturer, vendor or pharmacy network agreements.

- "Prescription Drug Charge" shall mean the amount that, prior to application of the Plan's cost-share requirement(s), County is obligated to pay for a Covered Drug dispensed at a Retail Pharmacy or Cigna Home Delivery Pharmacy, including any ingredient cost, applicable Dispensing Fee, service fee, and tax. The ingredient cost charged to County may be expressed as, for example, a discount off of AWP or other benchmark price, or a MAC.

- "Rebate" shall mean retrospective formulary rebates received by Administrator pursuant to the terms of a formulary rebate contract negotiated independently and directly attributable to or arising from the utilization by Members of certain Covered Drugs manufactured, sold, marketed, or distributed by a manufacturer.

  However, "Rebates" shall exclude: (i) pricing adjustments, payments and credits made in the ordinary course by any manufacturer on account of product returns, delivery errors or shipping damage or losses arising from drugs and other products purchased from such manufacturer by or on behalf of Administrator (ii) pricing discounts paid or credited by a manufacturer to pharmacies affiliated with Administrator for prescription drugs and other products purchased from such manufacturer; (iii) any fees or other compensation paid by any manufacturer in consideration of any services, products, activities or programs performed, provided or implemented by Administrator or any of its affiliates for such manufacturer; (iv) Manufacturer Administrative Fees; (v) Value-Based Payments; (vi) any rebates or other amounts that are allocated to reduce and/or partially or wholly satisfy a Member's cost-sharing obligation for a Covered Drug; and (vii)

rebates or other amounts paid to Administrator for prescription drugs that are administered or otherwise provided to Members in providers' offices, home health care settings, or outpatient clinics.

- "Retail Pharmacy" shall mean any licensed retail pharmacy with which Administrator has contracted directly or indirectly with a third party, to provide Covered Drugs to Members, and is not a mail order pharmacy. A mail order pharmacy is a pharmacy that primarily fills and delivers pharmaceutical products via the mail service. The term "Retail", when immediately preceding the term "Brand Drug Claim", "Generic Drug Claim", "Specialty Drug Claim", "Specialty Brand Drug Claim", or "Specialty Generic Drug Claim" means that the resulting term (e.g., "Retail Brand Drug Claim") refers to such claim as dispensed by a Retail Pharmacy.

- "Specialty Drug" shall mean a pharmaceutical product, including a Covered Drug, considered by Administrator to be a Specialty Drug based on consideration of the following factors: (i) whether the pharmaceutical product is prescribed and used for the treatment of a complex, chronic or rare condition; (ii) whether the pharmaceutical product has a high acquisition cost; and, (iii) whether the pharmaceutical product is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Drug may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a pharmaceutical product will be considered a Specialty Drug. The term "Specialty," when immediately preceding the terms "Generic Drug" or "Brand Drug", means that the resulting term (e.g. "Specialty Generic Drug") refers to a Generic Drug or Brand Drug that is considered a Specialty Drug, respectively.

- "Specialty Pharmacy" shall mean a duly licensed pharmacy designated by or operated by Administrator or its affiliates that primarily dispenses Specialty Drugs or provides services related thereto; provided, however, that when the Cigna Home Delivery Pharmacy dispenses a Specialty Drug, it shall be considered a Specialty Pharmacy hereunder.

- "Submitted Cash Price" means the cash price submitted by the Participating Pharmacy as part of the adjudication for a pharmacy claim and included in the lesser of adjudication pricing logic.

- "U&C Charge" shall mean the price the applicable Retail Pharmacy would charge a regular cash-paying customer for a Covered Drug (and any services related to the dispensing thereof) on the day on which the Covered Drug is dispensed.

PHARMACY BENEFIT MANAGEMENT - SERVICES TO BE PROVIDED

1. Retail Pharmacy Network.

(a) General. Administrator shall maintain a Retail Pharmacy network. Retail Pharmacies included in the network shall provide Covered Drugs to which the Retail Pharmacies have access to Members during their normal business hours. A list of the Retail Pharmacies included in the network, as updated from time to time, shall be made available to Members online. Administrator maintains multiple networks and/or sub-networks and may periodically consolidate networks and/or migrate clients, including County, between networks and sub-networks. Administrator shall require each Retail Pharmacy included in the network to meet its requirements for participation in the Retail Pharmacy network, which include, but are not limited to, satisfaction of licensing and insurance requirements.

(b) Retail Pharmacy Audits and Overpayments. A Administrator affiliate shall conduct an automated review of 100% of all claims. Claims that are identified during an automated review as requiring additional review by Administrator's auditor, will then select a subset of claims for validation to ensure that each Retail Pharmacy is complying with the terms of its contract with Administrator. In the event that Administrator discovers that an overpayment has been made to a Retail Pharmacy, Administrator shall take reasonable steps to recover the overpayment pursuant to the terms of this Agreement.

(c) Independent Contractors. The Retail Pharmacies are independent contractors, and as such Administrator does not direct or exercise any control over the pharmacists at Retail Pharmacies or the professional judgement exercised by any pharmacies in the dispensing or filling of prescriptions or performing other pharmaceutical services. Neither Administrator nor any Administrator affiliate shall have any liability to County, any Member or any other person or entity for any act or omission of any Retail Pharmacy or it agents or employees.

(d) Collection of Cost Sharing. Administrator shall require Retail Pharmacies to collect all applicable Plan cost-shares from Members.

2. Cigna Home Delivery Pharmacy.

(a) General. Members may submit new or refill prescription orders for fulfillment through Cigna Home Delivery Pharmacy or such other mail service pharmacy that Administrator in its sole discretion may select from time to time. Such orders may be placed via mail, telephone, or electronic means. Subject to Applicable Law, County shall permit communication with Members regarding the availability and use of the Cigna Home Delivery Pharmacy, and potential cost savings associated therewith, and the provision of supporting services (e.g. pharmacist consultation) in connection with any prescription dispensed by the Cigna Home Delivery Pharmacy. Cigna Home Delivery Pharmacy shall deliver all drugs to Members in accordance with its standard procedures. For the purposes of clarity, Administrator does not exert direction or control over the pharmacists at Cigna Home Delivery Pharmacy in filling prescriptions or performing other pharmaceutical services.

(b) Cost Sharing. Members are responsible for the payment of the applicable cost sharing to Cigna Home Delivery Pharmacy for each prescription or prescription refill. County acknowledges that Cigna Home Delivery Pharmacy may suspend services to a Member who is in default of any cost-sharing obligations, in accordance with Cigna Home Delivery Pharmacy's standard credit policy. If payment of such cost-sharing has not been received from the Member within one hundred twenty (120) days of dispensing of the product, the Plan will be billed for the outstanding amount following the one hundred twenty (120) day collection period.

(c) Affiliation with Administrator. Accredo Health Group, Inc., ESI Mail Pharmacy Service, Inc., Express Scripts Pharmacy Inc., Express Scripts Specialty Distribution Services, Inc. and Lynnfield Drug, Inc. (dba Freedom Fertility Pharmacy) are licensed pharmacy affiliates of Administrator that fill and deliver Covered Drugs to Members via the mail service.

3. **Claims Processing**.

(a) General. Administrator, in accordance with Article IV of the Agreement, shall perform claims processing services for Covered Drugs dispensed by Retail Pharmacies or Cigna Home Delivery Pharmacy. In-network Claims shall be submitted via paper or electronically. Members using out-of-network covered services are required to submit a paper claim form. A separate charge may apply for the submission of any paper claim form, whether in-network or out-of-network. Administrator is not required to provide coordination of benefits (COB) services for Claims for drugs dispensed, and electronically processed, at a pharmacy; Claims may be processed without consideration of a Member's coverage under another plan.

(b) Drug Utilization Review. Administrator shall perform a concurrent Drug Utilization Review ("DUR") analysis of each prescription submitted for processing. Such DUR Analysis may include, for example: (1) prescribed dosage within a safe range; (2) drug-to-drug interaction; (3) drug-to-allergy interaction; (4) age-to-drug interaction; (5) duplicate therapy; (6) quantity limitations; and (7) days' supply. DUR processes shall not override the prescriber's, the pharmacist's or other health care provider's professional judgment.

4. **Utilization Management Program**. Administrator shall, in accordance with Article IV of the Agreement administer the Pharmacy Benefit utilization management program(s) identified in this Agreement. County acknowledges that Administrator's coverage policies and claims administration procedures, which are utilized across Administrator's self-funded and insured book-of-business to adjudicate claims and administer appeals, may change periodically. As an example of the coverage criteria that may apply to a pharmaceutical product, a Member may have to try one or more preferred pharmaceutical products, or demonstrate why trying the preferred pharmaceutical product(s) would be clinically inappropriate, in order to obtain coverage under the Plan for a given pharmaceutical product County further authorizes Administrator to allow coverage for a use that would otherwise be excluded in the event of co-morbidities, complications and other factors not expressly addressed by the coverage policies utilized by Administrator in reviewing Claims for coverage. Administrator may rely wholly upon information about the Member and the prescriber's diagnosis of the Member's condition. Administrator shall not substitute

its judgment for the judgment of the prescribing physician, nor shall it determine medical necessity or make other medical de terminations other than for coverage purposes.

5. **Rebate Management**. Administrator shall pay County amounts equal to the Rebate amounts specified in the Schedule of Financial Charges.

6. **Drug-Related Services**.

   (a) Specialty Drugs. Administrator shall process Claims regarding Specialty Drugs subject to the following provisions:

      (1) The Specialty Pharmacy shall fill prescriptions for Specialty Drugs based on the professional judgment of the dispensing pharmacist, accepted pharmacy practices and product guidelines.

      (2) A list of Specialty Drugs available via the Specialty Pharmacy shall be made available as in effect on the Effective Date, as set forth in Appendix B. After the Effective Date, County may request that Administrator provide it with an updated list of Specialty Drugs available via the Specialty Pharmacy. Only those Specialty Drugs on the Specialty Financial Guarantee Drug List shall be used for pharmacy financial guarantee calculation and exclusion purposes. Specialty Drugs not appearing on the Specialty Financial Guarantee Drug List will be treated as a non-specialty drug for pharmacy financial guarantee and exclusion purposes. The Specialty Financial Guarantee Drug List is subject to change by Administrator at its discretion and available upon request.

      (3) To the extent acting in the capacity as a mail order pharmacy, the Specialty Pharmacy shall ship Specialty Drugs to Members in accordance with its standard procedures.

      (4) Members are responsible for the payment of the applicable cost sharing to the Specialty Pharmacy for each prescription or prescription refill. County acknowledges that the Specialty Pharmacy may suspend services to a Member who is in default of any cost-sharing obligations, in accordance with the Specialty Pharmacy's standard credit policy. If payment has not been received from the Member within one hundred twenty (120) days of dispensing, the Plan will be billed following the one hundred twenty (120) day collection period.

      (5) For the purposes of clarity, Administrator does not exert direction or control over the pharmacists at the Specialty Pharmacy in filling prescriptions or performing other pharmaceutical services.

   (b) Compound Drugs. Administrator shall process prescribed Compound Drugs to the extent covered under the Plan. Administrator shall treat as Covered Drugs only those components of a Compound Drug that would otherwise be treated as Covered Drugs were they not part of a Compound Drug.

(c) Discount Card Program. In order to help reduce Member pharmacy costs, Administrator may partner and apply pharmacy discount card program market pricing where available for certain Generic Drugs. As such, certain, eligible claims may be processed by a pharmacy discount card provider when there is price favorability to the Member. Such claims will adjudicate at the pharmacy discount card market price as a cash claim. Claims will adjudicate in accordance with County's Plan design and clinical rules, and Member paid amounts may be applied toward deductible and out of pocket accumulator amounts unless County opts out of program enrollment. Claims processed under the program will be included in Rebate and pharmacy financial guarantees, where such guarantees apply. Member direct claims are excluded from the program. Program terms and conditions are subject to change upon no less than forty-five (45) days' prior notice.

7. Member Communications and Services.

(a) Member Communication. Administrator shall provide to Members an ID card and instructions to access Member materials online, including the Formulary, the Retail Pharmacy directory, Cigna Home Delivery Pharmacy information, and an out-of-network Claim reimbursement form.

(b) Rx Savings Messenger. Administrator may send personalized mailings to Members regarding the Generic Drugs and preferred Brand Drugs and savings available from Cigna Home Delivery Pharmacy.

(c) Call Center. Administrator shall maintain toll-free customer service lines twenty-four (24) hours per day, seven (7) days per week for the purpose of responding to inquiries from Members regarding Retail Pharmacy, Cigna Home Delivery Pharmacy or Claims issues.

8. Formulary Management; Clinical Programs; Other Services.

Administrator shall provide Formulary management services, which shall include implementing Formulary placement decisions and determinations to apply utilization management requirements made by Administrator. Administrator makes Formulary determinations based on consideration of clinical and economic factors. Clinical factors may include, but are not limited to, the Administrator P&T Committee's evaluation of the place in therapy, relative safety or relative efficacy of the drug, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the drug's acquisition cost including, but not limited to, assessments on the cost effectiveness of the drug and available Rebates. County acknowledges that the Formulary, utilization management requirements, and coverage policies used by Administrator to perform coverage reviews, including any changes made thereto, are adopted by County. When considering a drug for Formulary placement or other coverage conditions, Administrator reviews clinical and economic factors regarding enrollees as a general population across its relevant book-of-business. Administrator may also provide the clinical, safety and/or trend programs, or other programs and services to County, some of which may require payment of additional fees by County. If additional fees are required for such a program or service, Administrator shall include the fee in the Schedule of Financial Charges or otherwise communicate the same in writing to by County.

PHARMACY BENEFIT MANAGEMENT - PROGRAM OPERATIONS

1. **Implementation of Agreement**.

   (a) Project Plan. County and Administrator shall develop a mutually agreed upon implementation project plan with respect to the Agreement prior to the Effective Date or prior to the implementation with respect to any new Pharmacy Benefit under this Agreement following the Effective Date.

   (b) Initial Data and Commencement of Pharmacy Benefit Management Services. Prior to the Effective Date, County shall provide Administrator with all data and/or documentation necessary for Administrator to provide the services specified in this Agreement. Such data and/or documentation shall include, but is not necessarily limited to, claims history and Member prior authorization history. Assuming all data specified in the preceding sentence is received sufficiently in advance of the Effective Date, Administrator shall commence providing services under this Agreement as of the Effective Date.

2. **Timely Provision of Data by County**. County acknowledges that Administrator shall not be held responsible for, and shall be released from, fulfilling any obligation or performing any service under this Agreement if County or its designee does not provide accurate information in a timely manner.

3. **Reporting**. Administrator shall make available to County Administrator's standard reporting applications, subject to Applicable Law and Exhibit D, including, without limitation, HIPAA and state privacy laws.

4. **Claims Data**.

   (a) Retention. Administrator shall retain data with respect to Claims for at least ten (10) years from the date the prescription is filled. Following the close of such retention period, Administrator shall retain and dispose of such Claims data pursuant to its then-current standard policies and procedures, Applicable Law and the Business Associate Agreement described in the Agreement.

   (b) Disclosure to Vendor. Upon County's written request and subject to execution of a non-disclosure agreement acceptable to Administrator, Administrator shall provide prescription Claims data in its standard format to a vendor contracted with County and otherwise acceptable to Administrator solely for the purposes of such vendor's support of Plan administration functions. County agrees that its vendors may not utilize Claims data for any other purpose, including, without limitation, developing products and services, analyzing the Claims data against market benchmarks or Administrator competitors or adding to a normative database (even if de-identified and/or blinded as to Member and PBM/carrier) for the County's or vendor's commercial use. County shall be responsible for any use or disclosure of Claims data, or any services provided, by the vendor. Notwithstanding the foregoing, all audits of any pricing guarantees, Rebate-sharing obligations or Claims processing accuracy shall be conducted in accordance with the terms in this Agreement specifically relating to such audits.

This provision shall survive termination or expiration of the Agreement.

5. Pharmacy Claims Processing Audits.

(a) County may, to the extent specified below and at no additional charge, conduct a claims processing audit of Administrator's administration of Plan Benefits, once every Plan Year provided that the Agreement has been duly executed by County and County is current in the payment of all pharmacy claims under the Agreement. Audits may be initiated from February through October and new audits shall not be initiated until all parties have agreed that any and all prior pharmacy-related audits are closed. In order to balance the need to adequately support the audit process for all Administrator clients, with an efficient allocation of resources, employers who choose to audit one or more components of the pharmacy arrangement must do so through a single annual audit.

(b) Claims processing audits shall be subject to the following conditions: (1) the audit may take place while the Agreement is in effect or within one (1) year after the termination or expiration of the Agreement; (2) the initial audit period for a retrospective claims audit shall not exceed the twenty-four (24) months period immediately preceding Administrator's receipt of the request to audit; (3) County shall be responsible for its incurred costs regarding the audit; (4) County shall designate, with Administrator's consent, such consent not to be unreasonably withheld, an independent, third party auditor to conduct the audit (the "Auditor") so long as such Auditor is not engaged in providing services for County (including, but not limited to the Auditor's engagement as an expert witness in litigation against Administrator or its affiliates), or otherwise, that conflict with the scope or independent nature of the audit (as determined by Administrator acting reasonably and in good faith), and provided that County's Auditor executes a mutually acceptable confidentiality agreement; (5) County shall provide to Administrator at least thirty (30) days prior written notice of its intent to audit, and any request by County to permit an Auditor to perform an audit will constitute County's direction and authorization to Administrator to disclose PHI to the Auditor; (6) Administrator will provide all data as reasonably necessary for Auditor to perform the claims processing audit within thirty (30) days following the latter of the audit kick-off call and the confidentiality agreement being fully executed or, when applicable, as otherwise agreed upon by the Parties; (7) following Auditor's initial review of the claims, Auditor will provide Administrator in writing with all suspected categories of claim errors, if any, together with an electronic data file, in a mutually agreed upon format, containing up to three-hundred (300) claims, so that Administrator may evaluate and investigate Auditor's suspected errors; (8) Administrator will respond to the suspected errors within sixty (60) days from Administrator's receipt of such written findings; (9) upon receipt and review of Administrator's responses, Auditor will provide Administrator with a written report of Auditor's findings and recommendations before or at the same time such audit report is provided to County; (10) Administrator will respond to the audit report within thirty (30) days of the issuance of Auditor's report; (11) once both Parties have accepted the audit results, the audit shall be considered closed and final; (12) to the extent the mutually accepted audit results demonstrate claims errors, Administrator will reprocess the claims and make corresponding adjustments to County; (13) Administrator's obligations to respond within the designated periods above is conditioned upon a good faith and cooperative working relationship between County and/or its

Auditor and Administrator, including but not limited to no new or additional issues that appear in the final report that were not otherwise provided to Administrator during the preliminary review of suspected errors.

This provision shall survive termination or expiration of the Agreement.

6. Pharmacy Rebate Audits.

(a) County may, to the extent specified below, in accordance with the following requirements, and at no additional charge, audit Administrator's payment of Rebates provided that the Agreement has been duly executed by County and County is current in the payment of all pharmacy claims under the Agreement. Any Rebate audit shall occur following Administrator's issuance of the annual financial reconciliation to County once in each twelve (12) month period. Audits may be initiated from February through October and new audits shall not be initiated until all parties have agreed that all prior pharmacy-related audits are closed. In order to balance the need to adequately support the audit process for all Administrator clients, with an efficient allocation of resources, employers who desire to audit one or more components of the pharmacy arrangement must do so through a single annual audit.

(b) Rebate audits shall be subject to the following conditions: (1) County shall be responsible for its incurred costs regarding the audit; (2) County shall designate, with Administrator's consent, such consent not to be unreasonably withheld, an independent, third party auditor to conduct the audit (the "Auditor") so long as such Auditor is not engaged in providing services for County (including, but no limited to the Auditor's engagement as an expert witness in litigation against Administrator or its affiliates), or otherwise, that conflict with the scope or independent nature of the audit (as determined by Administrator acting reasonably and in good faith), and provided that County's Auditor executes a mutually acceptable confidentiality agreement; (3) Access to and audit of rebate agreements is restricted to a mutually agreed upon CPA accounting firm whose audit department is a separate stand-alone division of the business, which carries insurance for professional malpractice of at least Two Million Dollars ($2,000,000); (4) County shall provide Administrator with at least thirty (30) days prior written notice of its intent to audit, and any request by County to permit an Auditor to perform an audit will constitute County's direction and authorization to Administrator to disclose PHI to the Auditor; (5) the scope of records to be audited will include those records necessary to determine Administrator's compliance with its contractual Rebate payment obligations under the Agreement and Administrator will provide such data within thirty (30) days following the latter of the audit kick-off call and the confidentiality agreement being fully executed or, when applicable, as otherwise agreed upon by the Parties; (6) the Auditor may select for audit purposes the records of up to five (5) manufacturers for two (2) calendar quarters from the last reconciled plan year immediately preceding the written request to audit; (7) the audit shall be conducted at a mutually acceptable time during regular business hours at Administrator's offices where such records are located; (8) following Auditor's initial rebate audit, Auditor will provide Administrator with suspected errors, if any, and Administrator will respond to the suspected errors in no more than sixty (60) days from receipt of such findings; (9) records shall not be removed or photocopied without Administrator's express written consent; (10) for the sole purpose of confirming compliance with the audit confidentiality agreement, Auditor will first submit in

draft to Administrator, and prior to submission to County, its Rebate audit report, so that Administrator can confirm that no terms of the applicable rebate agreements which are confidential, are disclosed in the audit report; (11) the Auditor shall provide its final audit report to Administrator and County at the same time; (12) Administrator will respond to the audit report within thirty (30) days of the issuance of Auditor's report; and (13) the Auditor may disclose the aggregate amount of Rebates due County but no other details of Administrator's rebate contracts of which the Auditor is apprised, if any.

This provision shall survive termination or expiration of the Agreement.

7. **Pharmacy Financial Guarantee Reconciliation Audits**.

(a) County may, to the extent specified below and at no additional charge, conduct a Financial Guarantee Reconciliation audit once every Plan Year following Administrator's issuance of the annual financial reconciliation to County, provided that the Agreement has been duly executed by County and County is current in the payment of all pharmacy claims under the Agreement. Audits may be initiated from February through October and new audits shall not be initiated until all parties have agreed that all prior pharmacy-related audits are closed. In order to balance the need to adequately support the audit process for all Administrator clients, with an efficient allocation of resources, employers who choose to audit one or more components of the pharmacy arrangement must do so through a single annual audit.

(b) Financial Guarantee audits shall be subject to the following conditions: (1) the audit may take place while the Agreement is in effect or within one (1) year after the termination or expiration of the Agreement; (2) such audit may cover up to two prior reconciled contract years to the extent such prior contract years have not previously been audited; (3) County shall be responsible for its incurred costs regarding the audit; (4) County shall designate with Administrator's consent, such consent not to be unreasonably withheld, an independent, third party auditor to conduct the audit (the "Auditor") so long as such Auditor is not engaged in providing services for County (including, but not limited to the Auditor's engagement as an expert witness in litigation against Administrator or its affiliates), or otherwise, that conflict with the scope or independent nature of the audit (as determined by Administrator acting reasonably and in good faith), and provided that County's Auditor executes a mutually acceptable confidentiality agreement; (5) County shall provide Administrator with at least thirty (30) days' prior written request for the audit, and any request by County to permit an Auditor to perform an audit will constitute County's direction and authorization to Administrator to disclose PHI to the Auditor; (6) Administrator will provide all data as reasonably necessary for Auditor to determine that Administrator has performed in accordance with its contractual obligations regarding the financial guarantees, and Administrator will provide such data within thirty (30) days following the latter of the audit kick-off call and the confidentiality agreement being fully executed or, when applicable, as otherwise agreed upon by the Parties; (7) any adjustments resulting from the audit will be based upon the actual Claims reviewed and not upon statistical projections or extrapolations, as the Auditor will be furnished with 100% of the paid Claims processed during the applicable contract period for purposes of the audit; (8) following Auditor's initial review and prior to the submission of its written audit report, the Auditor will provide Administrator in writing with all of the suspected errors, if any, and Administrator will respond to such suspected errors within sixty (60) days from Administrator's receipt of such preliminary

findings; (9) Administrator will respond to any audit report issued by the Auditor within thirty (30) days of the issuance of same; and (10) Administrator will reconcile mutually agreed upon amounts due to County within a reasonable period of time following mutual agreement regarding any amount due to the County. Administrator's obligations to respond within the designated periods above is conditioned upon a good faith and cooperative working relationship between County and/or its Auditor and Administrator, including but not limited to no new or additional issues that appear in the final report that were not otherwise provided to Administrator during the preliminary review of suspected errors.

This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT - FUNDING AND PAYMENT OF CLAIMS; CHARGES

1. **Funding and Payment of Claims**. With respect to Pharmacy Benefits, (1) Administrator may withdraw funds from the Bank Account for the purposes specified in Article V of the Agreement five times per month, and (2) any recovered overpayments shall be credited to County via a line item on its invoice, less the fee set forth on the Schedule of Financial Charges.

2. **Retroactive Member Changes and Terminations**. Notwithstanding anything in the Agreement to the contrary, County shall remain responsible for all charges and Bank Account Payments incurred or charged through the date Administrator processed County's notice of a retroactive change or termination of a Member's enrollment in the Plan. Notwithstanding anything to the contrary in Article VI.3 of the Agreement, with respect to Pharmacy Benefits, Administrator generally will implement eligibility updates received from County that adhere to Administrator's standard electronic format as soon as reasonably practicable following receipt of such updates.

PHARMACY BENEFIT MANAGEMENT - FIDUCIARY ACKNOWLEDGMENTS
Administrator offers pharmacy benefit management services for consideration by County and other entities. The general parameters of such services and the supporting systems have been developed by Administrator as part of Administrator's administration of its general business as a pharmacy benefit manager for entities that sponsor group health plans. The Parties have negotiated the terms of this Agreement in an arm's-length fashion. Except to the extent Administrator conducts the final level of internal appeal as set forth in Article IV.3 of the Agreement, the Parties assert that neither Party intends that Administrator shall be a fiduciary with respect to Pharmacy Benefits for either ERISA (if applicable) or state law purposes, and neither Party shall name Administrator or any of its affiliates as a "plan fiduciary" with respect to its management of Pharmacy Benefits. County acknowledges and agrees that Administrator (i) does not have discretionary authority or control respecting management of the Pharmacy Benefits, and (ii) does not exercise any authority or control respecting management or disposition of the assets relating to Pharmacy Benefits or of County. Rather, County retains all such authority and control. The Parties agree that, upon reasonable notice, Administrator shall have the right to terminate its Pharmacy Benefit services under this Agreement to any Plan and/or Members located in a state that requires a pharmacy benefit manager to be a fiduciary to County, the Plan or a Member. This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT - FINANCIAL ARRANGEMENTS	
1.	**General**. Administrator contracts with its PBM affiliate for the provision of pharmacy benefit services and financial arrangements. As such, Administrator or its PBM affiliate, directly or indirectly contract on their own accounts with Retail Pharmacies and Cigna Home Delivery Pharmacy to dispense covered pharmaceutical products to County's Members, and not on behalf of, or for the benefit of, County or the Plan; accordingly, any discounts or other remuneration Administrator or its PBM affiliate earns under an arrangement with a Retail Pharmacy or Cigna Home Delivery Pharmacy are obtained for, and inure to, the sole and exclusive benefit of Administrator or the PBM affiliate, and not the County or the Plan. Amounts paid by Administrator or its PBM affiliate or by the PBM affiliate for Retail Pharmacy or Cigna Home Delivery Pharmacy for Brand Drug, Generic Drug, or Specialty Drug Claims may or may not be equal to the amount charged to County and/or Member. If the amount paid by County and/or Member does not equal the amount paid by Administrator or its PBM affiliate or by the PBM affiliate to a particular pharmacy, Administrator and its PBM affiliate will absorb or retain such difference. Administrator may directly or indirectly contract for Rebates, Manufacturer Administrative Fees, and other remuneration on its own behalf and for its own benefit, and not on behalf of County or the Plan. As an example of other remuneration other than Rebates or Manufacturer Administrative Fees that Administrator may earn, Administrator may also directly or indirectly earn pharmaceutical manufacturers remuneration in connection with value payments and/or services that Administrator provides to County ("Value-Based Payments"). Notwithstanding anything in this Agreement to the contrary, any Value-Based Payments earned by Administrator are separate and apart from any Rebates or Manufacturer Administrative Fees that Administrator directly or indirectly earns from pharmaceutical manufacturers, and Administrator may retain any Value-Based Payments it earns. As examples of the value payments and/or services that Administrator may provide to County in connection with Value-Based Payments that Administrator may earn, Administrator may provide care management or other services to County and/or remit to County monetary credits if Members discontinue therapy on certain pharmaceutical products. Information regarding any services, and/or monetary credits or other financial value, for which County may be eligible with respect to specific pharmaceutical products or therapeutic classes/conditions, including the products for which monetary

credits or other financial value may be available to County, the amount of that value, and other payment terms, is available upon request. Any value payments and/or services provided by Administrator to County are subject to change or termination by Administrator as the value program(s), if any, offered by Administrator change(s) or terminate(s). Accordingly, Administrator retains all right, title and interest to any and all actual Rebates, Manufacturer Administrative Fees, Value-Based Payments, and other remuneration received directly or indirectly from manufacturers. Administrator may provide County amounts equal to all or some portion of the Rebate and Manufacturer Administrative Fee amounts, or other financial value generated in connection with any value program(s), allocated to County, if any, and as specified on the Schedule of Financial Charges, from Administrator's general assets (neither County, its Members, nor County's Plan retains any beneficial or proprietary interest in Administrator's general assets). Rebate and Manufacturer Administrative Fee amounts received vary based on factors including, without limitation, County-specific utilization, the volume of utilization as well as Formulary position applicable to the drug or supplies, and adherence to various formulary management controls, benefit design requirements, and Claims volume. County acknowledges and agrees that neither it, its Members nor its Plan will have a right to interest on, or the time value of, any Claim payments charged by Administrator to County or any Rebate, Manufacturer Administrative Fee or other payments received by Administrator during the collection period of moneys payable under this section, if any, and that Administrator shall retain any such remuneration. For purposes of this provision, the term Administrator shall also include and mean Administrator's PBM affiliate, Express Scripts, Inc.

2. **Affiliates**. Cigna Home Delivery Pharmacy may maintain product purchase discount arrangements and/or fee-for-service arrangements with pharmaceutical manufacturers and wholesale distributors in its capacity as a mail service and/or specialty pharmacy. Cigna Home Delivery Pharmacy may contract for these arrangements on its own account in support of its pharmacy operations, and not on behalf of, or for the benefit of, County or the Plan. Accordingly, Cigna Home Delivery Pharmacy retains the sole and exclusive benefit of any difference between its acquisition cost for a pharmaceutical product and the amount charged to County under this Agreement. Further 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 Administrator offers to entities that sponsor group health plans. Discounts and fee-for-service payments received by Cigna Home Delivery Pharmacy are not part of the pharmacy benefit management formulary rebates or associated administrative fees or charges paid to Administrator in connection with Administrator's pharmacy benefit management formulary rebate programs.

This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT - OBLIGATIONS UPON TERMINATION

Upon notice of termination of this Agreement, the following provisions shall apply with respect to Pharmacy Benefits:

a) County shall notify Members at least thirty (30) days prior to the termination of the Agreement becoming effective of any transition to a successor pharmacy benefit manager.

b) If mutually agreed upon by Administrator and County, Administrator shall provide services following termination of the Agreement at Administrator's then-prevailing rate. Such services, if any, shall be determined by mutual agreement of Administrator and County in advance of the termination of the Agreement becoming effective.

c) Upon request by County and subject to execution of a nondisclosure agreement acceptable to Administrator, Administrator shall transition Claims files and/or history to the pharmacy benefit manager or other third party specified by County and otherwise acceptable to Administrator. Any disclosure of Claims files and/or history shall be limited to the information the successor pharmacy benefit manager or other third party needs to implement or administer County's pharmacy benefits. Administrator shall not be required to directly or indirectly release, and County shall not release, PBM Proprietary Information to any such third party.

d) Upon termination of the Agreement for any reason, the Parties shall handle Confidential Information, PBM Proprietary Information and Protected Health Information (as defined in the Business Associate Agreement attached as Exhibit D) pursuant to the terms of the Agreement.

This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT - CONFIDENTIALITY

1. **General**. County acknowledges and agrees that Administrator's PBM Proprietary Information constitutes competitively sensitive trade secrets, and that its misuse or mis-disclosure could result in material financial and legal loss or liability to Administrator, its affiliates and their respective subcontractors. Administrator shall not be required to disclose PBM Proprietary Information to County except to the extent necessary for County to exercise any audit rights expressly provided hereunder or perform other Plan administration functions. If Administrator discloses PBM Proprietary Information to County, or, if Administrator consents, to the County's vendor or designee, Administrator may require County, or its vendor or designee, to execute a non-disclosure agreement specifically relating to the requested PBM Proprietary Information. County agrees that it and its vendors may not utilize PBM Proprietary Information for any purpose other than performing Plan administration functions, including, without limitation, developing products and services, de-identifying, blinding or analyzing the PBM Proprietary Information against market benchmarks or Administrator competitors or adding to a normative database for the County's, or vendor's or designee's, commercial use. For the purposes of clarity, information shall not cease to qualify as PBM Proprietary Information if County or its vendor or designee de-identifies and/or blinds the PBM Proprietary Information such that the information cannot be traced or identified to a Member or Administrator, its affiliates or their respective subcontractors. County shall be solely responsible for any disclosure of PBM Proprietary Information by Administrator to County or its vendor or designee, or any

subsequent use or disclosure by County or its vendor or designee, or services provided by the same. Notwithstanding anything herein to the contrary, in no event will Administrator be required to disclose to County, or its vendor or designee, information related to, or including, its pharmacy network agreements, vendor agreements or pharmaceutical manufacturer agreements.

2. **Compelled Disclosures**. If at any time County, or its vendor or designee, is required by law, court order or other valid legal process to disclose any Confidential Information, it will promptly notify Administrator prior to any such compelled disclosure and, upon request, cooperate with Administrator in seeking a protective order or other available relief to contest or limit the scope of such compelled disclosure.

3. **Return or Destruction of Information**. At any time upon Administrator's request or upon expiration or termination of this Appendix A or the Agreement, whichever occurs first, County will, at Administrator's option, promptly deliver, or, as the case may be, compel its vendor or designee to deliver, to Administrator all PBM Proprietary Information or other Confidential Information (or such portion thereof as requested) and not retain any copies in whole or in part of such PBM Proprietary Information or other Confidential Information, or securely destroy or dispose, or, as the case may be, compel its vendor or designee to destroy or dispose, of those portions of documents and other materials in any form, including electronic form, prepared by or received by the County or its vendor or designee, that contain or reflect such PBM Proprietary Information or other Confidential Information. County, or its vendor or designee, shall certify such return and destruction, as the case may be, to Administrator.

Appendix B - Cigna Home Delivery Pharmacy Specialty Drug List

THIS SPECIALTY DRUG LIST IS CONFIDENTIAL, PROPRIETARY INFORMATION OF ADMINISTRATO.. IT IS PROVIDED SOLELY FOR COUNTY'S PLAN ADMINISTRATION PURPOSES. RE-DISCLOSURE IS STRICTLY PROHIBITED EXCEPT AS OTHERWISE PROVIDED BY APPLICABLE LAW. ADMINISTRATOR RESERVES ALL LEGAL RIGHTS AND REMEDIES TO ENFORCE THESE PROHIBITIONS ON USE AND DISCLOSURE.

The Specialty Drug List shall be provided separately to County, and is hereby incorporated into the Agreement by reference, inclusive of any changes made subsequent to Administrator's initial issuance of the Specialty Drug List to County to the pharmaceutical products included on the Specialty Drug List or the discounts, if any, pertaining to such pharmaceutical products. Upon County's request on or after the Effective Date, Administrator shall provide to County an updated Specialty Drug List.

- For pharmacy pricing guarantee purposes, only those Specialty Drugs on the Specialty Financial Guarantee Drug List shall be used for pharmacy pricing guarantee and exclusion purposes. Specialty Drugs not appearing on the Specialty Financial Guarantee Drug List shall be treated as a non-specialty drug for pharmacy pricing guarantee and exclusion purposes. The Specialty Financial Guarantee Drug List is subject to change by Administrator at its discretion and available upon request.

New-to-Market Specialty Products. Specialty Drug Claims, excluding Limited Distribution Drugs and Exclusive Distribution Drugs, that are for new-to-market drugs will have a minimum market-introduction guaranteed discount of 11.45% off the drug's AWP.

Appendix C - SaveOnSP Program

1. The SaveOnSP Program is a Member cost share savings program available when the County makes certain pharmacy benefit plan design changes such that program specialty prescription drugs are designated as non-essential health benefits with respect to federal PPACA essential health benefit requirements, and County establishes Member cost share at amounts that allow the receipt of manufacturer-supported patient cost share assistance in accordance with Program parameters ("Program"). Designated specialty drugs under the Program may be revised twice on a calendar year basis.

2. County will be responsible for the payment of Program fees which shall be 25% of program savings and for any applicable tertiary and residual cost share. The Program fees shall be measured and calculated based on the Program's standard savings and fee calculating methodology. Payment of Program fees shall be charged to the Bank Account and invoiced on a monthly, incurred basis.

3. In order to make available Program services, Administrator is providing County's claims data to Administrator's approved third-party vendor ("Vendor") on a periodic basis to facilitate such Vendor's provision of the Services. Members' claims data is being provided under an applicable business associate agreement with such Vendor and in accordance with HIPAA including, but not limited to, the minimum necessary standards. Vendor may communicate with County's Member in order to provide Program services.

4. County acknowledges and agrees that Administrator and Vendor is not a legal advisor and do not render any legal counseling or advice regarding the provision of Program services or benefit designs adopted by County. County understands and agrees that it is implementing a third party specialty drug program administered by Vendor. Neither Administrator nor Vendor is responsible for ensuring that County or County's employee benefit plans independent from or in conjunction with the Program services comply with any Applicable Law including but not limited to laws, regulations, rules, ordinances and/or other guidance related to or associated with relevant Federal and State Anti-kickback laws; IRS rules; ERISA; the Affordable Care Act, state insurance department regulations, state consumer protection requirements, or other federal state or local laws or regulations, including but not limited to laws, regulations, rules, ordinances and/or other guidance related HSA-eligible high deductible health plans (including but not limited to Code Section 223) notwithstanding anything to the contrary. Administrator hereby advises County to seek legal advice and County acknowledges that it will consult with its own legal counsel regarding the operation, administration, and establishment of its plans and the appropriateness of the Program. Neither Administrator nor Vendor shall be liable to County or any person if any plan fails to comply with any such requirement. County is solely responsible for determining whether to implement the Program for its HSA-eligible high deductible health plan and addressing any compliance issues related to such implementation.

5. In addition to other provisions set forth in this Agreement, it is understood and agreed that for purposes of the Program, County (or the relevant plan sponsor and/or plan administrator) have full and final authority and responsibility for the plans, plan assets, and plan operation. Neither Administrator nor Vendor is a fiduciary (as defined under ERISA or state law) of Administrator clients' plans. Administrator, Administrator Affiliates and Vendor do not: (a) have any discretionary authority or control respecting management of Administrator clients' plans' prescription benefit programs or (b) exercise any authority or control respecting management or disposition of the assets of Administrator clients' plans. All such discretionary authority and control with respect to the

management of Administrator clients' plans and plans' assets are retained by Administrator clients and/or Administrator clients' plans.

6. If County fails to timely pay in full all applicable Program fees, Administrator reserves the right to suspend or terminate the services under the Program, in addition to any other rights and remedies available to Administrator under this Agreement and Applicable Law.

7. Administrator reserves the right to modify, revise, or terminate the Program due to market conditions that have a material impact on the Program at any time.