ADMINISTRATIVE SERVICES CONTRACT
(Hereinafter, the "Contract")
by and between

Clear Creek County
(Hereinafter called the "Client")

and

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Hereinafter called the "Company")

Whereas, the Client desires to provide benefits for certain classes of individuals (hereinafter called "Members") in accordance with a self-insured employee welfare benefit plan(s) (hereinafter called the "Plan"); and

Whereas, except as specifically provided herein, the Client will retain all liabilities under the Plan, and the Company will provide the agreed upon services to the Plan without assuming any such liability; and

Whereas, the Plan is an employee benefit plan and the Client, who is both the fiduciary of the Plan and the Plan Administrator, hereby retains the Company to provide services for the Plan in accordance with the following terms and conditions;

Now, therefore, in consideration of the payments to the Company as provided herein, and subject to the terms and conditions contained herein, it is hereby agreed as follows:

Section 1. Definitions

As used in this Contract, its Appendices and attachments, unless otherwise specifically provided:

A. "Affiliate" means a person or entity within the same Common Control Group as determined under the Internal Revenue Code section 414(c) and the regulations thereunder, and for Company includes a person or entity with whom the Company operates under a joint marketing or joint venture Contract.

B. "Anniversary Date" means 12 months from the Effective Date and the same date (January 01) each subsequent year.

C. "Average Wholesale Price" or "AWP" means 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 pharmacy at the time that the Covered Drug is adjudicated. Company 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 such alternative benchmark with a different pricing source. Any such change may result in a change to the Target Pricing (as defined herein) administered by Company under this Agreement.

D. "Brand Drug" or "Brand" shall mean a pharmaceutical product covered under the Plan's pharmacy benefit that is a prescription drug, including over-the-counter drugs dispensed pursuant to a prescription, medicine, agent, substance, device, supply or other therapeutic product that is not a Generic Drug. For the purposes of the ingredient cost discount Target Pricing, a Brand Drug excludes, and a Specialty Drug includes, a Specialty Brand Drug.

E. "Cigna Home Delivery Pharmacy" means a duly licensed pharmacy operated by Company or its affiliates, where prescriptions are filled and delivered via the mail service.

F. "Claim Payment Recovery" is a recovery of a claim payment, or a portion thereof, that (based on applicable Plan terms and provisions) is identifiable to a specific Member and is recoverable because that payment:

i. is in excess of the benefit amount otherwise payable;
ii. should not have been paid;
iii. did not take into account other forms of insurance or coverage, which paid or should have paid before the Plan; or
iv. is paid to the wrong payee(s).

Claim Payment Recovery shall not include the services described in the "Subrogation and Right of Recovery" provision in the "Other Financial Provisions" Section.

G. "Contract Month" means a calendar month.

H. "Contract Year" means that period of 12 consecutive months that begins on the Effective Date and each subsequent Anniversary Date; provided however, that the Company and the Client may agree to treat any period other than twelve months as a Contract Year.

I. "Coverages" are a class of benefits provided by the Client on a self-insured basis.

J. "Covered Drug" shall mean a prescription drug, including an over-the-counter drug dispensed pursuant to a prescription, biologic, medicine, agent, substance, device, supply, and other therapeutic product that is prescribed for a Member and is covered under the Plan's pharmacy benefit.

K. "Dispensing Fee" means an amount paid to a pharmacy for providing professional services necessary to dispense a Covered Drug to a Member.

L. "Effective Date" will have the meaning as set forth in Section 12.

M. "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

N. "Formulary" means the list of FDA-approved prescription drugs and supplies, and related coverage policies, developed and managed by Company across its self-funded and insured group book of business and that is selected and adopted by Client. The drugs and supplies included on the Formulary, and the terms of related coverage policies, will be modified by Company 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 Company makes to the Formulary and/or related coverage policies are hereby adopted by Client.

O. "Generic Drug" or "Generic" means a pharmaceutical product covered under the Plan's pharmacy benefit, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the FDA as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient(s), and which is identified as such in Company's master drug file using indicators from First Databank, Medi-Span, or other nationally recognized source as used by Company across its book of business on the basis of a proprietary algorithm, a summary of which may be made available for review by Client. Client shall sign a confidentiality agreement acceptable to Company relating specifically to such summary. The reference to a drug by its chemical name does not necessarily mean that the product is recognized as a generic for adjudication, pricing or copay purposes. For the purposes of the ingredient cost discount Target Pricing, a Generic Drug excludes, and a Specialty Drug includes, a Specialty Generic Drug for ingredient cost discount purposes. For the purposes of the ingredient cost discount Target Pricing, Generic Drug also excludes, and a Brand Drug includes, a drug that is either marketed under three (3) or fewer 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 pharmaceutical wholesaler.

P. "Health Information" means any information, including "Protected Health Information" defined in the HIPAA Privacy Appendix, related to the past, present or future physical or mental health condition of a Member or

the provision of health care to a Member or the past, present or future payment for the provision of health care to a Member that identifies or could reasonably be used to identify a Member.

Q. "Manufacturer Administrative Fees" shall mean administrative fees paid by pharmaceutical manufacturers or other third parties to Company or its affiliate or subcontractor directly in connection with administering, invoicing, allocating and collecting Rebates.

R. "Member" means any employee, or covered dependent if any, as defined by the Plan including those whose coverage under the Plan is being continued under the COBRA health continuation provision, if any, of the Plan. Member shall be the same as a Covered Person.

S. "Party" means the Client and/or the Company and when used collectively is "Parties."

T. "Plan" means that Employee Welfare Benefit Plan(s) established by the Client within the meaning of ERISA and the benefits described in the Summary Plan Description constitute benefits available under the Plan and are referred to collectively in this Contract as "the Plan."

U. "Plan Administrator" shall have the meaning ascribed to the term "administrator" as defined in ERISA and shall have a comparable meaning for non-ERISA plans.

V. "Prescription Drug Charge" means, prior to application of Member cost-share requirements, if any, the discounted rate payable by Client for a drug covered under the Plan's pharmacy benefit.

W. "Rebate" means remuneration directly or indirectly paid to Company from any pharmaceutical manufacturer or other third party as a result of the inclusion or exclusion on a Formulary, coverage status, or volume or value of Covered Drugs manufactured, sold, marketed, or distributed by the manufacturer or third party, and that is directly attributable to the utilization of such Covered Drugs by Members. Provided, however, that "Rebate" 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 Company; (ii) pricing discounts paid or credited by a manufacturer to pharmacies affiliated with Company 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 Company or any of its affiliates for such manufacturer; (iv) Manufacturer Administrative Fees; and (v) Value-Based Payments.

X. "Retail Pharmacy" means any licensed retail pharmacy with which Company 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.

Y. "Specialty Drug" or "Specialty" means a covered drug considered by Company 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.

Z. "U&C Charge" means 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.

AA. "Value-Based Payments" means remuneration that Company directly or indirectly earns from pharmaceutical manufacturers in connection with value payments and/or services that Company may provide to Client. As examples of the value payments and/or services that Company may provide to Client in connection with Value-Based Payments that Company may earn, Company may provide care management or related services to Client. Information regarding any value payments or services for which Client may be eligible with respect to specific pharmaceutical products or therapeutic classes/conditions, including, but not limited to, any program terms and conditions, is available upon request. Any value payments and/or services provided by Company to Client are subject to change or termination by Company as the value program(s), if any, offered by Company change(s) or terminate(s).

Section 2. Services

The Company will provide the services listed in the Services Appendix. The Company will process claims consistent with the claim administration policies and procedures then applicable to the Company's own health care insurance business and in accordance with the time frames and other rules set forth in applicable law and regulations. The Client hereby delegates to Company the authority, responsibility and discretion to determine coverage under the Plan based on the eligibility and enrollment information provided to Company by the Client. The Client also hereby delegates to Company the authority, responsibility and discretion to: (i) make factual determinations and to interpret the provisions of the Plan to make coverage determinations on claims for Plan Benefits; (ii) conduct a full and fair review of each claim which has been denied; (iii) decide level one appeals of claims and notify the Member or the Member's authorized representative of its decision. The Client will ensure that all summary plan description materials provided to Members reflect this delegation of discretionary authority. Such Services shall be performed in accordance with the terms of the Client's Plan and applicable law and regulations.

The Company may provide additional Services without the prior consent of the Client subject to subsection 4.B of this Contract. The Company shall perform Services in accordance with the terms of the Plan, including but not limited to the terms of the summary plan description. If the Client has not adopted a final summary plan description, the Company will process benefit payments in accordance with its standard policies and procedures for the benefits selected by the Client as set forth on the master application form, in which case the Company will not be responsible for any act that it takes consistent with those standard policies and procedures. However, in the event that the Client amends its Plan to include items that the Company either cannot or will not administer, nothing herein shall be construed to require the Company to so administer said Amendments but, rather, this Contract shall remain in full force and effect as if said Amendments had not been made.

All appeals shall be conducted in accordance with policies and procedures established by the Company, which may be changed from time to time at the discretion of the Company consistent with, applicable law and regulations.

External expert reviews may be required on a consultative basis as part of the internal appeal process, or as required under applicable law following exhaustion of the internal review process. The fees for external review which are the responsibility of the Client are dependent on the nature and complexity of the issue on appeal and the number and expertise of the reviewers.

Section 3. Banking Arrangements

A. Establishment and Maintenance of Transfer Account. With respect to all Plan's claims and Client's obligations under this Contract, except as otherwise provided elsewhere in this Agreement or in any Appendices, the Client shall establish and maintain a bank account ("the Transfer Account") and make available funds in the Transfer Account sufficient to honor the Client's claim administration fee, premium and any other financial obligations under this Contract.

B. Right of Company to Demand Monies from Transfer Account. The Company shall have the right to demand monies from the Transfer Account on a Weekly basis for health claims and on a Monthly basis for health premium and other Client obligations under this Contract in the amounts sufficient to satisfy the Client's obligations under this Contract that have been incurred as of the date of demand, including past due, over due or other unsatisfied obligations, if any. The Company shall not be authorized to demand monies from the Transfer Account for any purpose other than in order to satisfy the Client's obligations under this Contract.

C. Notice to Bank of Company's Rights. The Client shall notify the bank (i) that the Client has authorized the Company to demand monies from the Transfer Account, and (ii) that the bank shall honor any such demand from the Company without reservation or proof of rights of any kind whatsoever and (iii) that if the Transfer Account does not have sufficient funds to cover any demand by the Company that the bank shall honor such demand pursuant to the overdraft protection established by the Client.

D. Overdraft Protection. The Client shall ensure that the Transfer Account has overdraft protection in an amount not less than (i) for the first three Contract Months, the monthly average of the expected obligations under this Contract for that Contract Year, (ii) for any other Contract Month, the monthly average of the immediately prior three month's demands by the Company, and (iii) for any month after termination of this Contract, one hundred fifty percent (150%) of the monthly average of the immediately prior three month's demands by the Company. The Client may establish a line of credit against which demands for funds from the Transfer Account may be made. Such line of credit shall be deemed to be overdraft protection.

E. Maintenance of Transfer Account after Termination of Agreement. The Client shall continue to maintain the Transfer Account pursuant to the terms of this Section 3 for 15 months after the termination of this Contract. If the Client has not purchased run-out protection, then the Client shall continue to maintain the Transfer Account for a period of sixty (60) days following the termination of this Contract for the purpose of permitting the Company to make payments for items including but not limited to pharmacy benefits, vendor payments and surcharges.

Section 4. Payments to the Company

A. Service Fees. The Client shall pay the Company the fees as communicated separately to the Client by the Company in writing that shall form part of this Contract. Charges for hourly services, if any, will be determined in accordance with the Company's established time allocation procedures, and those of other organizations from whom hourly services are purchased. These charges will be made only if both parties agree on the Company's providing any hourly services.

Printed material created at the Client's request and not listed in the Services Appendix will be billed separately, when furnished.

(1) The Company shall deliver to the Client a written proposal including but not limited to proposed fees prior to the beginning of each Contract Year. Subject to sub-section 4.A.2 of this Contract, for the first Contract Year the proposed fees shall become final and enforceable on the earlier of (i) the Effective Date, or (ii) when Client begins to receive the Services described in this Contract regardless of whether this Contract has been executed. Subject to sub-section 4.A.2 of this Contract, for any other Contract Year the proposed fees shall become final and enforceable on the Anniversary Date.

(2) The Client acknowledges that the proposed fees are based on information provided by the Client including but not limited to the number of Members that the Plan will cover. The Company has the right to revise any fees retroactively to the Effective Date or the Anniversary Date, as applicable, to reflect actual participation in the Plan. Any difference between payments made under the proposed fee and the fees set forth in the Rate Confirmation will be collected from or credited to the Client on the next scheduled transfer or payment date.

(3) Any proposed fees will not become final unless and until the Company so states in writing, signed by an officer in Company's Denver office, delivered to the Client.

B. Amendment of Fees.

(1) Block of Business Amendment. The Company may change the fees under this Contract at any time provided that (i) the Company provides 60 days advance notice to the Client which notice will be deemed delivered if delivered in writing to Client's broker; (ii) any increase in fees is reasonable in relation to the Services provided or added under this Contract; and (iii) any increase in fees is applied in a non-discriminatory manner to substantially all other similarly situated customers taking into consideration factors including but not limited to customer size, state(s) in which the customer is located, and

Coverages. The 60 day notice requirement recited in clause (i) above shall be reduced to the soonest practicable time to the extent that the change is due to a governmental or regulatory requirement that takes effect sooner than said 60 days.

(2) Client Specific Amendment. Notwithstanding subsection 4.B.1 above, the Company may change the fees under this Contract:

(a) if the Client amends its Plan to modify benefits, said change of fees to be effective on the date of the change of benefits; or

(b) if the Company's cost of operation is increased by virtue of a change in charges to the Company by a governmental unit, but such adjustment shall be limited to the amount of the change; or

(c) on any Anniversary Date of this Contract and except as otherwise set forth in this Contract, not more than once in any Calendar year; or

(d) upon addition or deletion of coverage for any subsidiary or affiliated company or corporate division of Client; or

(e) if the Stop Loss Policy or stop-loss contract, if any, between the Client and the Company is terminated; or

The effective date of the change in fees under subsections (b) through (e) above will be the effective date of the event that causes such change. Modification of fees may be made by written notice to the Client by the Company. If the Client pays such revised fees or fails to object to such revision in writing within 15 calendar days of receipt, this Contract shall be deemed modified to reflect the fees as communicated by the Company.

C. Client Payments. The Client shall pay the Company (i) an amount equivalent to the claims incurred by Members under Client's Plan as determined by the Company, including costs and expenses of investigation of claims, (ii) the deficit permitted to be recovered by the Company, if any, and other payments owed by the Client, other than premium, under such Stop Loss Policy or Stop-Loss Contract, if any, (iii) the Client's portion of network access fees and pay for performance payments, if any, as determined by the Company, under fee arrangements negotiated by the Company with health care providers.

D. Drug Claims. The Client shall pay the Company the amounts that the Company bills for (i) Covered Drugs provided to Members during the preceding billing period, plus (ii) Dispensing Fees for such Covered Drugs during the preceding billing period, plus (iii) sales tax where required by law. For specific prescriptions for Covered Drugs, Company shall charge Client, net of any Member cost-share requirement payable for the prescription for the Covered Drug, the lesser of the Prescription Drug Charge or, as applicable, submitted U&C Charge for such Covered Drug.

Company shall charge Client for Covered Drugs in accordance with the estimated Target Pricing terms set forth in the written proposal or similar document provided by Company to Client, which proposal or similar document is incorporated herein by reference. The "Target Pricing" means the aggregate, average Dispensing Fee target and aggregate, average AWP drug discount target(s) for covered drugs dispensed by Retail Pharmacies and Cigna Home Delivery Pharmacy that Company achieves during the then-current calendar year when measured with respect to aggregate utilization of covered drugs, including covered drugs for which enrollees' cost-share payments are equal to some or all of the entire amount payable for the drug, under the subset of its group client book of business for which the applicable pricing suite is administered (the "Book of Business"). The Target Pricing assumes an estimated level and distribution of utilization across the relevant Book of Business of covered drugs in less than an 83-day supply and greater than or equal to 83 day supplies at Retail Pharmacies and Cigna Home Delivery Pharmacy, respectively. The Target Pricing includes (i) separate aggregate, average AWP drug discount targets for three drug categories: Brand Drugs, Generic Drugs, and Specialty Drugs dispensed by Retail Pharmacies and Cigna Home Delivery Pharmacy, and (ii) an aggregate, average Dispensing Fee target for Brand Drugs, Generic Drugs, and Specialty Drugs dispensed by

Retail Pharmacies and Cigna Home Delivery Pharmacy. The average, aggregate drug discounts and average, aggregate Dispensing Fee that Client pays in a given calendar year with respect to its Plan utilization, which is not guaranteed to meet or exceed the Target Pricing, may vary from the Target Pricing due to a number of factors, such as, without limitation, the Client's drug utilization patterns (e.g. which drugs Members utilize, the days' supply of drugs utilized by Members, and at which pharmacies the Members obtain drugs), changes to the Plan design or pharmacy network, or fluctuations in Plan enrollment.

Amounts paid in connection with reimbursement to a Retail Pharmacy for a Covered Drug may or may not be equal to the amount charged to Client for the same Covered Drug. If the amount paid by Client does not equal the amount paid by Company to a particular Retail Pharmacy, Company will absorb or retain such difference. Company contracts on its own account with Retail Pharmacies to dispense Covered Drugs to Members, and not on behalf of, or for the benefit of, Client or the Plan; accordingly, any discounts or other remuneration Company earns under an arrangement with a retail pharmacy are obtained for, and inure to, the sole and exclusive benefit of Company, and not the Client or the Plan. Moreover, 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 contracts for these arrangements on its own account in support of its pharmacy operations, and not on behalf of, or for the benefit of, Client 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 Client under this Agreement for the same.

E. Mental Health and Chemical Dependency Claims. For covered mental health and chemical dependency services from participating providers, Company shall apply discounts available under an agreement with its affiliate, Cigna Behavioral Health, Inc. Client shall pay Company 33% of the savings (billed charges less negotiated rate x .33) which shall be taken from Client's bank account when the claim for covered services is paid.

F. Premiums for Insurance. The Client and the Company acknowledge that (i) the Client may have purchased one or more insurance Policies from the Company, including but not limited to insurance for group life and accidental death and dismemberment, excess loss or stop-loss insurance, long term disability insurance, dental insurance, vision insurance, or other insurance, and that (ii) the Client is required to pay the Company a periodic premium for such Policies. In lieu of making one or more separate premium payments to the Company for such insurance, the Client shall make available in the Transfer Account funds sufficient to honor any and all such premium payments, as the Company demands them. The Client acknowledges that proposed premiums are based on information provided by the Client including but not limited to the number of Members that the Plan will cover. The Company has the right to revise premiums retroactively to the Effective Date or the Anniversary date, as applicable, to reflect actual participation in the Plan. Any difference between payments made under the proposed premiums and the actual premiums will be collected from or credited to the Client on the next scheduled transfer or payment date.

G. Lack of Sufficient Funds. To the extent that the bank in which the Transfer Account is established and maintained honors any demand for funds by the Company in an amount less than the amount demanded, for any reason whatsoever, any funds that are made available to the Company from the Transfer Account shall be applied first to the payment of the Company's service fees, second to any premiums for insurance, and third to the payment of claims. To the extent that any check, draft, money order, or other financial instrument issued by or on behalf of the Client is honored in an amount less than the face amount of that instrument, for any reason whatsoever, any funds that are made available to the Company through such instrument shall be applied in the same manner. Nothing in this subsection shall limit in any way the Company's rights under this Contract, including but not limited to the right to terminate this Contract.

H. Amounts Payable under Appendices. The Client shall pay the Company all amounts, if any, that result from costs associated with programs or services provided in any of the Appendices that form part of this Contract.

I. Initial Deposits. If an initial deposit is required with respect to any Stop Loss Policy or Stop-Loss Contract issued to the Client by the Company, the Client shall pay the Company such initial deposit as specified by the

Company. Such initial deposit shall be credited against payments due for the first Contract Month under this Contract.

Section 5. Pharmacy Benefit Management Services

A. PBM Services

The Company shall arrange for pharmacy benefit management (PBM) services to be provided to support the pharmacy benefit provided under the Client's Plan, as follows:

(1) Company shall provide access to networks of retail pharmacies and mail order or specialty pharmacies. The mail order and specialty networks shall include, without limitation, Cigna Home Delivery Pharmacy. Cigna Home Delivery Pharmacy, a participating mail order pharmacy for the Plan, is an affiliate(s) of Company.

(2) Company shall provide, consistent with its then-standard claims management policies and procedures, electronic claims adjudication services for drugs processed for coverage under the Plan's pharmacy benefit. The claim adjudication system will include all Plan information regarding deductibles, copayments, coinsurance, Member out-of-pocket maximums, benefit maximums and any other features of the Plan to be used in processing claims. Participating pharmacies may collect from Members at point of sale the amount specified in the Plan

(3) Company shall provide Formulary management services and utilization management services to the Client. Company's Formulary and drug coverage policies, which Client hereby adopts, and inclusive of any changes, are made available on Company's public website. Company reserves the right to change the drug Formulary or utilization management programs adopted by Company at any time and without prior written notice, and Client hereby adopts any such changes. Company makes Formulary determinations, and develops coverage criteria, on its own behalf and based on consideration of clinical and economic factors. Clinical factors may include, but are not limited to, the Company'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. When considering a drug for Formulary placement or other coverage conditions, Company reviews clinical and economic factors regarding enrollees as a general population across its book-of-business.

B. Services to be provided by Company

The Company shall provide the following support for the pharmacy expense benefit provided under the Client's Plan:

(1) Based on information it receives from the Client, timely notify PBM of the identity of each Member eligible for pharmacy expense benefits under the Plan, the date the Member becomes eligible, and the date the Member's eligibility ends.

(2) The Client acknowledges that Cigna Home Delivery Pharmacy may from time to time engage in therapeutic interchanges.

(3) Cigna Home Delivery Pharmacy may dispense drugs to Members even if the prescription is not accompanied by the correct copayment, coinsurance or deductible amount. If the Company is charged for any uncollectible copayment, coinsurance or deductible amount, the Client shall be liable to Company for such amount if reasonable collection efforts by the PBM fail.

C. Limitations

The Company does not direct or exercise any control over the professional judgment exercised by any pharmacist in dispensing prescriptions or providing pharmaceutical-related services at a PBM participating pharmacy. Participating pharmacies are independent contractors, not subcontractors or agents of the Company, and the Company shall not have any liability to Client or any Member for any loss or damage related to or in any way growing out of any act or omission of any PBM participating pharmacy or its agent or employee.

D. Payments

Client shall pay Company in accordance with the Drug Claims provision in Section 4, "Payments to the Company" of this Contract.

Section 6. Client Responsibilities

A. Payments to Company. The Client shall make all payments under this Contract as provided in this Contract.

B. Enrollment and Determination of Eligibility.

(1) The Client shall:

(a) handle all routine inquiries from Members, including inquiries from Members seeking information concerning enrollment in the Plan and information concerning particular aspects of the Plan; and

(b) handle all enrollment activity; and

(c) notify Members of their right to apply for benefits and make available the necessary enrollment, claim and any other necessary forms supplied by the Company; and

(2) In determining any person's right to benefits under the Plan, the Company shall rely on eligibility information consistent with the description in the Plan and information provided by the Client. It is mutually understood that the effective performance of this Contract by the Company will require that it be advised on a timely basis by the Client of the identity of persons covered under the Plan, and the effective date or the termination date of their coverage.

For the purpose of determining fees under this Contract, a Member shall be considered to be:

(a) enrolled on the date of enrollment if the enrollment date is the first date of the month;

(b) enrolled on the first day of the first month following the month in which the Member is eligible to receive benefits under the Plan where the enrollment is after the first of the month; and

(c) terminated on the last day of the last month in which the Member is eligible to receive benefits under the Plan.

Retroactive adjustments for Member enrollment or termination may be allowed for periods not exceeding sixty (60) days. Client shall remain liable to Company for any claims that were paid on the Plan's behalf for services rendered to a Member after the date on which Client seeks to terminate said Member but prior to Company's notification of such retroactive termination.

C. Plan Benefits. The Client is solely responsible for all Plan benefit claims and all expenses incident to the Plan and no payment of Plan benefits by Company shall be construed as an assumption of any of Client's liability for such Plan benefits. The Client shall be responsible for:

(1) any state premium or similar tax, or any other tax, however denominated, including any penalties and interest payable with respect thereto, assessed against the Company on the basis of and/or measured by the amount of Plan benefits administered by the Company pursuant to this Contract; and

(2) the consequence to any person not a Party to this Contract of any acts or omissions of Client occurring during the operation of this Contract that are alleged to be a breach of fiduciary duty or a breach of duty or trust, or other contractual duty, regardless of the source of law serving as a basis for such allegation; and

(3) subject to Section 7 of this Contract, any amounts that the Company may become liable for which arise from any legal action or proceeding related to the recovery of benefits under the Plan or the administration of the Plan; and

(4) reviewing any and all claims/benefits payment reports for any readily apparent errors, including but not limited to those related to eligibility, furnished by the Company to the Client and informing the Company of any errors contained therein within thirty (30) days of the Client's receipt of said claim report(s). Failure to so notify the Company shall constitute a waiver on the Client's part of any claim against the Company for failure to accurately pay the claim at issue. Any claims errors shall not be an excuse for failing to make payments that are due the Company; and

(5) reimbursing the Company for any Plan benefits paid by the Company to Members who were not eligible for Plan benefits and with respect to whom the Client does not timely notify Company of such Member's lack of eligibility; and

(6) reimbursing any health care service provider with whom Company has entered into a provider agreement that has provided covered services to a Member if Company is unable to or otherwise does not reimburse such provider as a result of Client's failure to fulfill its obligations under this Contract, including but not limited to funding the Benefits Plan Account for payment of claims. Client further acknowledges that it is responsible, and is a guarantor of payment, for covered benefits under the Plan. Client acknowledges that, through provider contracts negotiated by Company, Client, as the party responsible for payment, has certain obligations not inconsistent with the terms of this Contract, even though it is not a party to such provider agreements. As such, any contracted provider may bring a cause of action or assert a lien against Client for payment of any unpaid claims for covered services rendered by such provider to a Member; and

(7) reimbursing the external review expenses described in Section 2.

(8) reimbursing Company for any Plan benefits it may be required to pay as a result of any legal action.

D. COBRA. If COBRA is applicable to the Client, the Client is responsible for performing the duties required by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), including but not limited to:

(1) notifying Members of their rights under COBRA when they first become covered under the Plan;

(2) notifying Qualified Beneficiaries of their continuation rights upon occurrence of Qualifying Events;

(3) establishing and maintaining reasonable procedures for members and Qualified Beneficiaries to notify Plan of Qualifying Events, disability or changes in personal information;

(4) notifying Company of COBRA-related eligibility changes as they occur. This includes but is not limited to termination of coverage under the Plan as a result of a Qualifying Event, subsequent election of COBRA coverage, payment of premiums and reinstatement of coverage;

(5) distributing and processing elections forms;

(6) billing and collection; and

(7) termination of COBRA coverage.

At the Client's option, and for a fee payable to the Company, the Company will itself perform some or all of the required duties. The Client may also arrange with a third party administrator to perform some or all of the required duties. If the Client or a third party administrator performs COBRA administration, the Company shall have no liability resulting from the failure of the Client, including its employees, directors, or officers, or the third party administrator other than to fulfill any of the Company's obligations under COBRA or this Contract.

E. Delays. The Company shall not be responsible for any delay in the performance of its duties under this Contract or for non-performance hereunder, if such delay or non-performance is caused or contributed to in whole or in part by the failure of the Client to promptly furnish any required and/or requested information.

F. 5500 Forms. The Client shall be solely responsible for the submission of 5500 Forms. However, the Company shall provide the Client with applicable Schedules A or C and such other information in its possession reasonably necessary for Client to submit said forms. In the event the Company fails to provide the Client with the requisite information prior to the filing deadline, Client is not relieved of its responsibility to timely submit said 5500 Forms. Rather, Client should submit the 5500 forms and indicate therein that it has not yet received all pertinent information. The Company's failure to provide the Client with the information necessary to submit the 5500 forms shall not be a material breach of this Contract and the Client's sole remedy for such failure shall be termination of this Contract.

G. Furnishing of Information. The Client will furnish the Company with correct and complete information required by the Company to provide the Services, including, but not limited to, eligibility information, identity of agents and brokers, confirmation of overdraft protection on the Transfer Account, information to verify contribution and participation requirements with respect to insurance Policies issued by the Company, and a copy of the Plan and any Amendments thereto. The information will be furnished at the times and in such manner as the Company may request. The Company will assume that all such information is complete and accurate and will be under no duty to question the accuracy of such information. The Company, at its discretion, may charge additional reasonable fees to the extent additional services are requested or required because information is not furnished, is incomplete or inaccurate or is not furnished at the time or in the manner as requested.

H. Compliance with Appendices. The Client shall comply with the Appendices that form part of this Contract.

I. Client's Affiliates and Subsidiaries. With advance notice to and the approval of the Company, the Client may include the employees and dependents of subsidiary or affiliated companies under this Contract. The Client will be liable for the payment of all amounts due to the Company and for the adequate funding of the Client's Transfer Account with regard to Members of subsidiary and affiliated companies.

J. Disclosures to Members. The Client will distribute summary plan descriptions to all Plan participants as required by law. The Client will make all disclosures to Members under its Plan as required by applicable law including but not limited to the Health Insurance Portability and Accountability Act, the Newborns' and Mothers' Health Protections Act, the Women's Health and Cancer Rights Act, and COBRA. Client is solely responsible for communicating any Plan modification or amendment to Members or individuals considering enrolling in the Plan.

K. Third Party Legal Proceedings. As stated in the provisions of Section 2 regarding claims appeals, the Company is delegated certain authority and discretion related to claim determination and claims appeals. Client shall be responsible for its own defense of any legal action brought by a third party related to the Plan. Nothing herein shall require the Client to defend the Company in an action in which the Company is a named party. Nothing herein shall require the Company to defend the Client. The Company and the Client shall cooperate in the defense of any legal proceeding and each Party will furnish the other and its legal counsel all pertinent information regarding the proceeding.

L. Special Payments. To the extent that the federal or state government, through Medicare, Medicaid, the Veterans Administration or any other agency or entity asserts a reimbursement right against the Client or

against the Company, pursuant to that agency's or entity's rights under applicable law (for example, Medicare Secondary Payor rules), with respect to claims processed by the Company under this Contract, the Client shall be responsible for reimbursing any such amounts determined to be owed. Any such reimbursements requested of the Company during the currency of this Contract prior to its termination shall be processed by the Company in the same manner as any other claim and the Company shall be responsible for asserting any applicable defenses to such request. Any such reimbursements requested of the Company after the termination of this Contract shall be forwarded to the Client for resolution. The Company will work with the Client to determine whether and to what extent such request must be honored and the Client shall promptly make any necessary payment. This provision shall survive the termination of this Contract.

Section 7. Authority to Control and Manage the Plan

A. Agency Relationship. The Company, in performing its duties under this Contract, is acting only as an agent of the Client, and the rights and responsibilities of the parties shall be determined in accordance with the law of agency except as otherwise herein provided.

B. Company's Control and Authority.

(1) The Company and the Client agree that while this Contract is in effect the Company and its delegates shall have exclusive authority to provide the Plan with the services listed in the attached Appendices, and that during such time the Client shall not undertake on its own nor shall it authorize or allow any other person or entity to provide any of those services without the prior written consent of the Company.

(2) The Company and the Client agree that the Company shall have no liability under this or any other agreement between the said parties with respect to any payment of benefits or other act that violates the provisions of subsection 8.B.1 above.

C. Client's Control and Authority. The Client acknowledges that, except as expressly provided in this Contract, it and the Plan Administrator have the exclusive authority to control and manage the Plan. The Client expressly agrees that the Company is not the Plan Administrator. The Client expressly agrees that the Company is not the named fiduciary or a fiduciary of the Plan and that neither the Client nor the Plan Administrator will designate the Company as the named fiduciary or a fiduciary of the Plan. Nothing in this Contract shall be deemed to confer upon the Company any power, discretion, authority or control over the Plan or Plan assets, or responsibility for the terms or validity of the Plan, or to alter, modify, or waive any terms or conditions of the Plan, or to waive any breach of any such terms of conditions, or to bind the Client.

D. Plan Documents. The Client acknowledges that the Plan Administrator has the responsibility to provide Members with a summary plan description ("SPD") and to make available to Members certain other materials and information. To the extent that the Client uses documents, including but not limited to the benefit booklet(s), or other materials or information provided to the Client by the Company for the purpose of satisfying the Plan Administrator's obligations, the Client acknowledges that it adopts such documents and other material and information as its own as if they were drafted and made available to Members by the Client and under the authority of the Plan Administrator. The fact that the Company has drafted or assisted in drafting any document, including but not limited to the benefit booklet(s), or provided any other materials or information to the Client, shall not be construed as the exercise of any discretion, authority or control by the Company with respect to the Plan, and shall not be construed as establishing any fiduciary, agency, trust, or other similar relationship whatsoever between the Company and the Client or between the Company and any Member.

E. Relationship to Members. Nothing herein will be deemed to impose upon the Company any obligation to any Member under the Plan and Members shall not have any rights hereunder and shall not have any right to bring an action based on this Contract.

Section 8. Right to Audit Claims

Client may audit Company's payment of Plan Benefits in accordance with the following requirements:

A. Client shall provide to Company a scope of audit letter and the fully executed Claim Audit Agreement, a sample of which is attached hereto, together with a forty-five (45) day advance written request for audit.

B. Client may designate with Company's consent (which consent shall not to be unreasonably withheld) an independent, third-party auditor to conduct the audit (the "**Auditor"**).

C. Client and Company will agree upon the date for the audit during regular business hours at Company's office(s).

D. Except as otherwise agreed to by the parties in writing prior to the commencement of the audit, the audit shall be conducted in accordance with the terms of Company's Claim Audit Agreement attached hereto as "Claim Audit Agreement", which is hereby agreed to by Client and which shall be signed by the Auditor prior to the start of the audit.

E. If the audit identifies any claim adjustments, such adjustments will be made in accordance with this Agreement and based upon the actual claims reviewed and not upon statistical projections or extrapolations.

F. Client shall be responsible for its Auditor's costs.

Client may (as determined by Company based upon the resources required by the audit requested) be responsible for Company's reasonable costs with respect to the audit, except that while this Agreement is in effect there shall be no additional cost to Client for an audit of 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, provided that if Client has five thousand (5,000) or more employees who are Members, Client may conduct one such audit every Plan Year (but not within six (6) months of a prior audit); otherwise, Client may conduct one such audit every two (2) Plan Years (but not within eighteen (18) months of a prior audit). In the event Client requests to alter the scope of the claim audit, Company will endeavor to reasonably accommodate the Client's request, which may be subject to additional charges to be mutually agreed upon by the Client and Company prior to the start of the audit. In no event shall any audit involve Plan benefit payments made prior to the most recent two (2) plan years.

Section 9. Company's Use and Disclosure of Records

A. Confidentiality. The Company shall maintain the confidentiality of Health Information of Members, in accordance with the provisions of the HIPAA Privacy Agreement Appendix and any applicable state privacy laws, including, without limitation, 201 CMR 17.00: Massachusetts Standards for the Protection of Personal Information of Residents of the Commonwealth.

B. Ownership of Records. Subject to subsection A above, the original files and other records in the possession of the Company, regardless of the manner in which such records are kept, will be maintained in accordance with the Company's corporate record retention policy. Copies of such files and records may be made available, upon request and to the extent needed, to the Client.

Section 10. Collection of and Liability for Claim Payments Recoveries Not Including Subrogation and Right of Recovery

A. Payment Recoveries

The Company shall take appropriate steps as it would for its own business under similar circumstances to collect Claim Payment Recoveries. Company shall also take appropriate steps as it would for its own business under similar circumstances to collect pay for performance payments payable to Client or pay for performance overpayments (collectively "Pay for Performance Recoveries"). The Company shall not be required to initiate court proceedings to recover a Pay for Performance Recovery or a Claim Payment Recovery, but is expressly authorized to take all actions to pursue recovery including retaining counsel, settling and compromising claims, and delegating recovery to a third party vendor to assist it in its collection efforts. For any Pay for Performance Recoveries or Claim Payment Recoveries initially identified by the Company, the Company first attempts to pursue recovery itself. If the Company is unable to recover Pay for Performance Recoveries or Claim Payment Recoveries, it may retain a third party vendor(s) to assist with the recovery. In such instances, the amount of money returned to the Plan will be net of any fees charged by such vendor or counsel.

The Company's decision to retain a third party vendor(s) to assist with recovery may be based upon the amount of the Pay for Performance Recoveries or the Claim Payment Recoveries or other factors as determined by Company. The Company currently retains third party vendors to assist with recovery for Pay for Performance Recoveries and Claim Payment Recoveries that are in excess of specified minimum amounts. That threshold may change from time to time, at the Company's sole discretion. For further information on the Company's current practices, please contact your Company account representative.

For any Pay for Performance Recoveries or Claim Payment Recovery amounts that are first identified by a vendor, regardless of the cause, including but not limited to Payments made without regard to other coverage of the Member, if the Company uses the services of a vendor to collect the Pay for Performance Recoveries or Claim Payment Recovery, the Client agrees to reimburse the Company up to 35.4% of the returned Pay for Performance Recoveries or Claim Payment Recovery for collection costs.

B. Hospital Bill and Credit Balance Audits

(1) The Company shall perform hospital bill audits and credit balance account audits. Such audits are limited to those inpatient, outpatient, emergency and trauma hospitalization claims that the Company has identified as meeting its auditing guidelines (hereafter, "Claim").

Each hospital bill audit entails a comparison of billed services to services ordered and/or documented in the medical record. Upon conclusion of each hospital bill audit, the Company will present the applicable facility and/or provider with a billing listing the overcharges and undercharges, if any and reflecting the net total overcharges due or net undercharges payable, and will employ commercially reasonable efforts to recover the overcharges from the facility and/or provider. In the event that the audit results in net undercharges payable to the facility and/or provider, the Client agrees to pay any such net undercharges.

(2) As compensation for its services, the Client agrees to pay the Company the following fees, which fees or a part thereof may be paid to any third party vendor that assisted with the recovery:

(a) Fees equal to 35.4% of all audit savings which are recovered following the commencement of any hospital bill audit or credit balance account audit undertaken by the Company. The Company has the right to offset any fees owed to it by the Client against any audit savings recovery amounts.

(b) Fees equal to 35.4% of the identified audit savings should the Client request that the Company forego recovery of a specific overpayment or positive balance after the audit process is complete.

(c) Company reserves the right to change the rate of the fees by giving the Client at least sixty (60) days advance written notice of the change.

The fees stated in Section 11.B.2a and b above are inclusive of the Company's administrative and transactional charges and any third party vendor fees.

"Audit Savings'' means the net dollar amount of the overcharges less the undercharges as identified in the final audit summary report with respect to a hospital bill audit, or a dollar amount consented by a hospital as a positive balance at the conclusion of a credit balance account audit.

C. Claims in Process. Upon termination of this Contract for any reason other than the Company's breach, the Company shall continue to be authorized to provide recovery and auditing services with respect to all Claims in process on the termination date. Claims are considered in process if the Company or its third party vendor has evaluated, screened, audited or in any way processed it, including all Claims inventoried in Company's claim payment database.

D. Responsibility. The Company will not be responsible for Pay for Performance Recoveries or Claim Payment Recoveries that are caused directly or indirectly by the Client, its agents or employees, or providers. The Company retains the sole right to determine whether to seek repayment from the payee.

E. Returns. The Company shall return to the Client any refund of an overpayment of Plan monies that it receives from a third party on behalf of a specific Member's account. The Company shall have the right to retain any returned overpayments that are received more than 15 months following the termination of this Contract.

Section 11. Term and Termination

A. Contract Term. This Contract shall be effective on January 01, 2023, (the "Effective Date"), and shall continue in force for one year, unless earlier terminated under this Section. This Contract shall expire at the end of the Initial Term, subject to the right of the Parties to renew the Contract as set forth herein, in which case, the Contract shall remain in force until the expiration of the period for which the Contract was renewed (the "Renewal Term"), unless earlier terminated under this Section.

B. Contract Renewal. The Company shall submit to the Client, not later than 30 days prior to the expiration of the Initial Term and any Renewal Term, the Company's proposed terms and conditions for the renewal of the Contract (the "Renewal Proposal"). If prior to the expiration of the Contract, the Parties do not agree on the terms and conditions under which the Contract will be renewed, unless expressly directed by the Client to discontinue Service as of the expiration date, the Company, in order not to disrupt the Services with respect to the Members, may elect to continue providing Services beyond the expiration date. In that case, this Contract shall be deemed to have been renewed under the terms and conditions of the Renewal Proposal in the same manner as if the Client had affirmatively assented to the Renewal Proposal, and this Contract shall be deemed to have been renewed. Notwithstanding anything above to the contrary, the Company shall not be obligated in any manner to provide Services after the expiration of this Contract, except to the extent expressly required to do so under another provision of this Contract. If the parties have not reached an agreement as to the proposed Terms and Conditions for renewal as of the renewal date, and therefore the proposed Terms and Conditions go into effect, then the parties will negotiate in good faith for a period not to exceed thirty (30) days in order to arrive at new Terms and Conditions. If no agreement is reached at the end of the thirty (30)-day period, then the Contract shall be in effect under the new Terms and Conditions subject to the Client's right to terminate according to Section 12. Once this Contract is renewed, whether by express agreement or by a deemed renewal under this Section, the Contract may be terminated only as set forth below in this Contract.

C. Termination Upon Notice. This Contract may be terminated:

(1) at any time by either the Company or the Client, provided written notice of such termination is given at least 31 days in advance of the effective date of the termination or as otherwise required by law; or

(2) by the Company upon Amendment of the Plan in a manner deemed unsatisfactory by the Company, and on notice to the Client, such termination to be effective on the effective date of such Amendment.

D. Immediate Termination. This Contract shall terminate immediately and without notice:

(1) at the option of the Company upon termination of the Stop Loss Policy or Stop-Loss Contract, if any, between the Company and the Client;

(2) upon failure of the Client to comply with any material term or condition of this Contract, such as but not limited to, failure to:

(a) make the payments as specified in the Section of this Contract entitled "Payments to the Company"; or

(b) fund any Transfer Account.

Suspension of Company's Performance. In lieu of treating this Contract as being immediately terminated upon the Client's failure to comply with any material or condition of the Contract as described above, the Company has the right to treat the Contract as being continued and to immediately suspend the Company's performance of its duties under the Contract including, but not limited to, the Company's claims processing duties. In exercising such rights, the Company will notify the Client of the Client's failure and request the Client to cure

such failure. It is the Client's duty to completely cure its failure within the Company's then prescribed time frame ("performance suspension period" and "cure period"), not to exceed ten days. The Company is not required to resume the performance of any of its duties until after the Client's failure is completely cured. This Contract shall terminate immediately and without notice after the expiration of the performance suspension period if the Client fails to completely cure its failure after the end of the applicable cure period.

E. Reinstatement after Termination. If the Company terminates this Contract under Section 12.C or 12.D, and the Client desires to reinstate this Contract, the Client may do so only if:

(1) the Company agrees; and

(2) the Client pays a Reactivation Fee of the greater of five hundred dollars ($500) or two percent (2%) of the average amount of the monthly claims for the last three months; and

(3) the Client pays all outstanding amounts plus interest accruing from the date of termination at the rate of the lesser of one and one-half percent (1.5%) per month or the maximum allowed pursuant to state law; and

(4) the Client reimburses the Company for any network access fees required to be paid by the Company on behalf of the Client following termination of this Contract.

F. Termination by Law. If any state or other jurisdiction enacts a law that prohibits or effectively prevents the continuance of this Contract, or the existing law is interpreted to so prohibit or effectively prevent the continuance of this Contract, the Contract shall terminate automatically as to such time or jurisdiction on the effective date of such law or interpretation.

G. Termination for Breach. In addition to the foregoing, if the Company has materially breached this Contract, or if Client commits a breach other than as set forth in Section 12.D hereof, and the non-breaching Party desires to terminate this Contract, the non-breaching Party shall give the breaching Party specific, written notice of the nature of the breach. The breaching party shall have 30 days to cure such breach. If the breach remains substantially uncured 30 days following the notice of breach, the non-breaching Party as of the end of such 30-day cure period may terminate this Contract.

H. Effect of Termination.

(1) If, on the date this Contract terminates the Client has not made all payments then due under this Contract the Company will have the right to immediately stop providing the Services, including but not limited to processing claims, on the effective date of such termination. In this case, information regarding all outstanding claims which are unpaid (regardless of when the claim was incurred and regardless of when the Company received the claim) or received after such date may be returned by the Company to the Client. In addition, the Client will notify each Member covered under the Plan of such termination.

(2) Upon termination of this Contract, or upon termination of individual Employee or Dependent coverages, it is the Client's responsibility to take reasonable steps to prevent further use of the ID cards by any Employee or Dependent post-termination. The Client will be responsible for reimbursing the Company for any claims incurred by the Company for any Employee or Dependent who is no longer covered by the Plan and who uses an ID card prior to the date the Client notifies the Company of such termination.

(3) For adjudication of claims incurred prior to the termination of this Contract and submitted for consideration within 15-month period immediately following the termination date hereof, the Client shall pay the Company an administrative fee calculated per Member covered on the first day of the last Contract Month prior to the end of this Contract. This run-out fee will be calculated for the first calendar month(s) and will be payable in the first month following the termination date of the Contract. The Client shall pay this non-refundable run-out fee as set forth in a separate written document. If Client chooses to purchase run-out protection, then the run-out fee shall be applied toward that protection. If Client does not purchase run-out protection, then the fee shall be applied toward Company's administrative costs for, amongst other things, denying claims and forwarding them to Client or its designee post-termination.

(4) With respect to claims incurred prior to and not processed before termination of this Contract, the Company shall not be responsible for processing the claims unless the Company agrees in writing to do so (in which case the Company shall process claims for a period not to exceed 15 months and the Client pays the run-out fee set forth in (3) above. However, the run-out fee shall be paid regardless of whether Company processes such claims.

Section 12. Subcontracting

The Company may perform the Services pursuant to this Contract, in whole or in part, through an Affiliate or other Contractor of its choosing. Company may, at its discretion, enter into subcontracting agreements with any organization of its choosing.

Section 13. Compensation to Agents or Brokers

The Client acknowledges that Company may pay reasonable compensation to the agent or broker of record. Any and all agents and brokers are hereby declared to be an agent(s) of the Client and not of the Company. An agent or broker is not a trustee of the Plan, a Plan Administrator, a named fiduciary of the Plan (within the meaning of ERISA Sec. 402(a)(2)), or a fiduciary who is expressly authorized in writing to manage, acquire, or dispose of the assets of the Plan on a discretionary basis. The Client shall notify the Company, in writing, if the Client changes its agent or broker. Changes shall be effective on the first day of the month following thirty (30) days after receipt of the notice of change. The Company shall not be responsible for recovering any payments made to the prior agent or broker and will not be responsible for any amount asserted to be owed to the new agent or broker that accrues prior to the receipt by the Company at its Group office and at its Denver, Colorado Office of the written notice from the Client. For the purpose of this Section, delivery of notice to any location other than Company's Group Office and its Denver, Colorado Office shall not constitute valid or effective delivery to the Company.

Section 14. Advertising

The Client will not use Company's name in any release or printed forms unless approved in advance by the Company.

Section 15. Other Financial Provisions

A. Savings Initiatives.

(1) In its sole discretion, the Company may undertake initiatives in addition to the services described in this Contract for the purpose of saving additional money for the Plan. Examples of such initiatives might include, but are not limited to, subrogation and right of recovery, provider bill/fee negotiation and discounts on claims from providers outside of the Company's primary network of providers, and COB identification and recovery when performed by a third party vendor.

(2) For purposes of pursuing savings under this provision, the Company may retain third party vendors.

(3) For its services in obtaining savings for the Plan, the Company shall be entitled to retain (i) for subrogation and right of recovery, the amount referred to in subsection 16.B below, and (ii) for all other savings initiatives, 35.4% of any savings realized.

(4) Company also 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 the Company, and/or

(ii) improve adherence to evidence based guidelines designed to promote patient safety and efficient patient care.

(5) Subject to the election by the Client, Company may also make available the SaveOnSP Program. The SaveOnSP Program is a Member cost share savings program under the prescription drug program

available when the Client 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 copay assistance. The program fee will be 25% of program savings plus any applicable tertiary cost share. Program savings shall be calculated based on the program's standard savings methodology, and payment of program fees shall be invoiced in accordance with program protocols. Additional terms and conditions of the SaveOnSP program are set forth in the attached SaveOnSP Appendix.

Vendor fees for these cost containment services shall be reimbursed from the Transfer Account. Specific vendor fees and care management program services are available upon request.

B. Subrogation and Right of Recovery. For purposes of subrogation and right of recovery, the Company will have the sole right to make claims under the Subrogation and Right of Recovery Provision contained in the Plan. In its sole discretion, the Company may litigate, negotiate, settle, compromise, release or waive any such claim. The Client hereby assigns to the Company all of its rights to make, litigate, negotiate, settle, compromise, release or waive any such claim. Claims subject to this subrogation and right of recovery section include, but are not limited to, recovery of covered expenses incurred by a covered person as the result of injuries or illness caused by a third party, recovery of covered expenses incurred by a covered person due to a work-related injury or sickness, and recovery of covered expenses through class action lawsuits. Recoveries under this Section will be distributed as follows:

(1) first, 35.4% of the gross recovery to the Company, and/or its designated vendor for services related to obtaining the recovery; and

(2) secondly, to the Company to be applied to reduce the Company's payment of Individual Stop-Loss Benefits under the Stop Loss Policy, if any, issued by the Company to the Client for the Member in respect of whom the recovery was obtained; and

(3) thirdly, to the Company to be applied to reduce the Company's payment of Aggregate Stop Loss Benefits under the Stop Loss Policy, if any, issued by the Company to the Client; and

(4) fourthly, the remainder, if any, to the Client.

Legal expenses will not be used when calculating the individual stop loss benefits, or the aggregate stop loss benefits, if any, pursuant to the Stop Loss Policy issued by the Company to the Client.

C. If the Controversy has not been resolved by Executive Review or Mediation, the resolution of the Controversy shall be governed by and construed in accordance with the internal laws of the State of Colorado, without reference to choice of law rules. The parties agree that venue in any action to enforce or interpret this Agreement shall be in the District Court of Clear Creek County in the 5th District for the State of Colorado.

D. Access Fees. The Company shall have the right to negotiate arrangements with third parties for the delivery to Members of services and benefits that are not otherwise covered under the Plan. The Company may retain any fees paid by the third parties pursuant to the arrangements.

E. Joinder to Lawsuits. The Company shall have no obligation to join any class action lawsuit(s) except as, in its sole discretion, it determines. In the event the Company joins such a lawsuit and receives money as part of an award or settlement, the Company may retain such moneys where the cost to return them would exceed fifty percent (50%) of the amount returnable or where the money is not identified with an individual Client or Member.

F. Surcharges/Assessments, etc. For any state that assesses a surcharge to fund the care for uninsured populations, finance the operation of risk pools or for any other purposes required by the state, the Company shall render such payments pursuant to the payment method elected or deemed elected by the Client and in accordance with that state's requirements. With respect to such surcharges or any other form of assessment, tax or similar charge relating to the plan that the plan or the Company may be required to pay, the Company

shall draw such funds from the Client's Transfer Account. Upon termination, Client agrees to allow Company to access the Transfer Account for a period of 15 months following the last day on which the Company is responsible for claims payment, so that Company has continued access to Client's funds in order to meet all surcharge obligations. In the event Company processes any claims following the fifteen-month post-termination period for which Client is responsible, Company shall calculate the surcharge due and send that amount, along with any requisite report, to Client for payment and submission to the state.

Section 16. Resolution of Disputes

Any dispute between the Parties arising from or relating to the performance or interpretation of this Contract ("Controversy") shall be resolved exclusively pursuant to the following mandatory dispute resolution procedures:

A. Any Controversy shall first be referred to an executive level employee of each Party who shall meet and confer with his/her counterpart to attempt to resolve the dispute ("Executive Review") as follows: The disputing Party shall give the other Party written notice of the Controversy and request Executive Review. Within twenty (20) days of such written request, the receiving Party shall respond to the other in writing. The notice and the response shall each include a summary of and support for the Party's position. Within thirty (30) days of the request for Executive Review, an employee of each Party, with full authority to resolve the dispute, shall meet and attempt to resolve the dispute.

B. If the Controversy has not been resolved within thirty five (35) calendar days of the request of Executive Review under Section 17.A. above, the Parties agree to mediate the Controversy in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Mediation ("Mediation"). The mediation shall be conducted in such city and state as to be determined by the mediator. Each Party shall assume its own costs and attorneys fees. The mediator's compensation and expenses and any administrative fees or costs associated with the mediation proceeding shall be borne equally by the Parties.

C. If the Controversy has not been resolved by Executive Review or Mediation, the resolution of the Controversy shall be governed by and construed in accordance with the internal laws of the State of Colorado, without reference to choice of law rules. The parties agree that venue in any action to enforce or interpret this Agreement shall be in the District Court of Clear Creek County in the 5th District for the State of Colorado.

This provision shall survive termination of this Agreement.

Section 17. Miscellaneous

A. Reliance. The Company shall be entitled to rely upon any communication believed by the Company to be genuine and to have been signed or presented by the proper party or parties. For verification of persons eligible for the Coverages provided under the Plan, the Company will rely solely upon information in its computer records at the time eligibility verification is requested. These records will be based upon eligibility information provided to the Company by the Client.

B. Notices. All notices and communications required under the terms of this Contract shall be given in writing by one Party addressed to the other:

(1) Notices or communications can be sent by first class mail, United Postal express mail, commercial courier express mail, facsimile transmission, electronic transmission or telegraph and are considered to be provided upon: (i) depositing in the U.S. Mail with postage prepaid if first class mail is used; or (ii) being received by the designated addressee if any other authorized modes of communication is used.

(2) Delivery of notices to the Client's broker shall constitute delivery to the Client unless the Client instructs the Company otherwise in writing.

(3) Notices to the Company shall be sent to the person or department as set forth in the Administrative Guide provided by the Company to the Client, or such other address as the Company may from time to time specify to the Client in writing.

(4) Except for notices sent to the Client's broker, notices to the Client shall be sent to the person designated as the Plan Administrator by the Client in the Company's administration system, as may be revised from time-to-time.

C. Waiver. Failure by the Client or the Company to insist upon compliance with any provision of this Contract at any given time or under any given set of circumstances shall not operate to waive or modify such provision or in any manner render it unenforceable, as to any other time or as to any other occurrence, whether the circumstances, are, or are not, the same and no waiver of any of the terms or conditions of this Contract shall be valid or of any force or effect unless contained in a written instrument specifically expressing such waiver and signed by a person duly authorized to sign such waiver.

D. Amendments. Except as otherwise set forth in this Contract, no alteration or modification of the terms and conditions of this Contract shall be valid or of any force or effect unless in each instance it is contained in a written instrument expressing such alteration or modification and executed for the Client and the Company by their officers duly authorized to execute such alteration or modification. This Contract may not be modified by any shrink-wrap, click-wrap, browse-wrap, click-through, web-based, online or use agreements ("**Click-Wrap**") that purport to be accepted or deemed accepted by download or online acknowledgment.

E. Assignment. Except as set forth elsewhere in this Contract and other than with respect to the right to receive money, neither Party shall transfer its rights or delegate its duties under this Contract without the express written consent of the other Party; provided, however, that the Company may transfer any portion of its rights or delegate any portion of its duties under this Contract to an Affiliate. The Client's reorganization, any merger in which the Client is not the surviving company, and any transfer of the Client's assets whether by bulk sale or otherwise, shall be deemed to be a transfer or delegation by Client. Any transfer or delegation by a Party in violation of this Section shall entitle the other Party to immediately terminate this Contract.

F. Inurement. This Contract shall be binding upon and shall inure to the benefit of the Parties hereto and their permitted respective successors and permitted assigns and delegees.

G. Force Majeure. In the event that either Party is unable to perform under this Contract on account of strikes, accidents, acts of Nature, severe weather conditions, inability to secure necessary labor, fire, governmental restrictions, computer system failure or any other reason which is beyond the reasonable control of the Parties, then performance under this Contract shall be excused for a reasonable period of time to enable the Parties to resume performance. If a Party is unable to resume its performance within such reasonable period of time, the other Party may terminate this Contract as herein provided.

H. Entire Contract. This Contract, including any application form, Appendices or supplements thereto, shall constitute the entire Contract between the Parties and shall govern the rights, liabilities and obligations of the Parties hereto, except as it may be modified in accordance with the provisions of this Contract. This Contract supersedes all prior proposals, representations, communications, negotiations and agreements between the Parties, whether oral or written.

I. Controlling Law. This Contract shall be construed in accordance with the laws of the State of Colorado without regard to conflict of law rules, and both Parties consent to the venue and jurisdiction of its courts.

J. Provisions Separable. The provisions of this Contract are independent of and separable from each other, and no provision shall be affected or rendered invalid or unenforceable by virtue of the fact that for any reason any other or others of them may be invalid or unenforceable in whole or in part. In the event any provision of this Contract shall be held illegal or invalid for any reason, by law or a court of competent jurisdiction, said illegality or invalidity shall not affect the remaining parts of this Contract, provided that the basic purposes hereof can be effectuated through the remaining valid and enforceable provisions.

K. Gender and Number. Any reference in the masculine gender herein shall be deemed to also include the feminine gender and vice versa, unless expressly provided otherwise. Wherever appropriate, any reference in this instrument in the singular shall include the plural, and any references in the plural shall include the singular.

L. Counterparts and Declaration of Signature. This Contract may be executed in any number of counterparts, each of which shall be deemed original, and said counterparts shall constitute but one and the same instrument. This Contract may be executed under a separate Declaration of Signature that sets forth that a signature appearing thereon has the same legal effect as a signature placed on this Contract.

M. Currency and Place of Payments. All sums payable to, or payable by, the Client pursuant to this Contract shall be payable in the lawful currency of the United States of America at its Bloomfield, Connecticut Office.

N. Headings. Section, sub-section or paragraph headings contained in this Contract are for reference purposes only and shall not affect the meaning or interpretation of this Contract.

O. Construction. This Contract is the result of arms length negotiations and shall not be strictly construed against either Party.

IN WITNESS WHEREOF, the Parties hereto have caused this Contract to be executed by their respective officers duly authorized to do so.

Dated: Denver, Colorado November 10, 2022

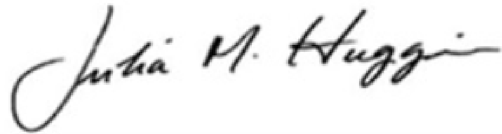
Clear Creek County

By: ________________
(Signature of Authorized Representative)

____
(Official Title)

____
(Date)

CIGNA HEALTH AND LIFE INSURANCE COMPANY



Julia M. Huggins, President

SERVICES APPENDIX
SERVICES TO BE PROVIDED BY THE COMPANY

To be attached to and made a part of the Administrative Services Contract

Effective January 01, 2023

By and between

Clear Creek County

and

CIGNA HEALTH AND LIFE INSURANCE COMPANY

The following services will be provided in condition with the administration of the Client's Plan:

- Drafting Assistance: benefit booklet(s) and Amendments with online access for members
- Health Plan Identification Card Preparation and Printing
- Preparation of enrollment procedures
- Assistance in plan enrollment
- Claim form preparation and printing
- Benefit determinations in accordance with the Plan
- Claims Processing in accordance with the Plan (Exception: Notwithstanding the terms of the Plan, Company shall not administer Member cost-sharing with respect to charges made by Cricket Health, Inc. for its personalized, evidence-based approach to managing chronic kidney disease and end-stage renal disease for clinically eligible Members in CA. Such cost-sharing expenses shall, instead, be reimbursed by the Plan. Not applicable if client has opted out. Not applicable to Members who are identified as having an HSA).
- Claim Check preparation and printing
- Premium collection and remittance for Affiliates (if applicable)
- Negotiation of basic fee arrangements with health care providers
- Creation and maintenance of a proprietary provider network
- Utilization Management and Case Management
- Quality assurance, including fraud prevention protocols and claim control practices
- Assistance with Member grievances and appeals
- Late applicant underwriting
- Claims Reports:
    - Monthly detail list of health paid claims
    - Monthly Basic Summary of Expenses by Subgroup, Class, Plan or benefits (medical, pharmacy, dental, vision, as applicable)
    - Monthly Pharmacy Benefits Financial Detail
    - Ability to identify claims payments in excess of certain dollar amount
    - Incurred claims and utilization data through consultative analytical report package
- Preparation of physician payment reports, including 1099s
- Actuarial cost estimates:
    - Review of past experience
    - Projection of expected future costs
    - Legislated changes in benefits
    - Plan modifications and benefit design advice
- Online Internet Access to provider directories, benefit and claim inquiry information, and summary plan descriptions
- 24-hour eligibility and claim status via Interactive Voice Response
- 24-hour, 7 days a week, 365 days a year customer service
- Pharmacy benefit management interface

- Execution of a Commission Agreement with Client's Broker/Producer of Record, if any
- Payment of Commissions to Client's Broker/Producer of record, if any
- Member Outreach for the then current Case Management, Specialty Case Management and Chronic Condition Management
- 24-hour Health Information Line
- Online wellness coaching programs for customers
- Information supporting customers through maternity and post-delivery care
- Cigna MotivateMe Program (customer incentives), if purchased
- Lifestyle Management program(s), if purchased
- Litigation Support Services, if purchased

- Upon request by the Client, Cigna Health and Life Insurance Company shall provide the following services to assist Client 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 ("SBC"), translation notice and glossary. (Applicable to all plans including HRA and FSA which are considered "group health plans" subject to the SBC requirements.)
  - Preparation of SBC, translation notice. Cigna Health and Life Insurance Company will not be responsible for any changes that Client makes to the SBC.
  - Provide SBC, translation notices prepared by Cigna Health and Life Insurance Company to Client electronically as well as any updates or material modifications.
  - Include in SBC a summary of benefits administered by carve-out vendor if Client or carve-out vendor provide Cigna Health and Life Insurance Company with necessary carve-out benefit information at least 12 weeks prior to the date the SBCs are to be delivered to Client.

- CHLIC will make available an internet-based self-service tool for use by Members, as well as certain data in machine-readable file format on a public website, as required under the Transparency in Coverage rule. Members can access the cost estimator tool on myCigna.com. Updated machine-readable files can be found on Cigna.com and/or CignaForEmployers.com on a monthly basis.
- Pursuant to Consolidated Appropriations Act (CAA), Section 106, CHLIC will submit certain air ambulance claim information to the Department of Health and Human Services (HHS) in accordance with guidance issued by HHS.
- Subject to change based on government guidance for CAA Section 204, CHLIC will submit certain prescription drug and health care spending information to HHS through Plan List 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.

- Additional Programs:
  - Offer or arrange for various entities to offer discounts, benefits, services or other consideration to Employees for the purpose of promoting their general health and well-being.

The Plan Administration Site Appendix
License Agreement for the Plan Administration Site

To be attached to and made a part of the Administrative Services Contract

Effective January 01, 2023

By and Between

Clear Creek County

AND

CIGNA HEALTH AND LIFE INSURANCE COMPANY

1. **Grant of License**

The Company agrees to grant Client a non-exclusive, non-transferable license to use the Company's proprietary Plan Administration Site solely for Client's internal purposes in connection with its administration of the Plan in accordance with this Contract while this Contract is in effect.

2. **Definitions**

For purposes of this Appendix the following terms shall have the meanings set forth below:

a. "Data" means:

   i. the pertinent identifying information about each employee and dependent whom Client reports as eligible for coverage through the Plan (including coverage under COBRA), the dates these individuals' coverage begins and ends, and the class and type of coverage for which each such individual is enrolled;

   ii. the number of employees and COBRA continuees enrolled for each class and type of coverage, the amount of life insurance, if any, applicable to each enrolled individual, and all other information necessary for Company to be able to verify the amount of premium and/or other fees due from Client.

b. "Plan Administration Site" services currently include, but are not necessarily limited to, the following applications, which may be enhanced, changed or terminated at any time in the sole discretion of Company without amendment of this appendix:

   i. *Financial Reporting* – Provides access to financial information associated with the payment of claims pursuant to the Plan.

   ii. *Billing* – Provides the ability to request and run billing statements for the Plan utilizing the eligibility information and the billing capabilities residing on Company's eligibility and billing systems.

   iii. *Eligibility Management* – Allows Client to perform the following eligibility maintenance functions: Add new employees and/or dependents, update information on existing employees and dependents, including but not limited to terminations, reinstatements, and COBRA election, add and/or update products, request ID cards.

   iv. *Eligibility Reporting* – Allows Client to report on Member eligibility utilizing Company's eligibility system.

   v. *Open Enrollment* -- Allows Client to select Plan benefits during Client's designated Open Enrollment period and allows Members to enter information to be approved by Client. Access necessary to update demographic information, add a dependent, modify dependent information, and reinstate a terminated dependent will also be available to the Client's representative.

vi. *Claim Status Information* – Allows Client the ability to view processed, pended claim information, and control pay claim information. Claim data will be updated nightly. Claim history will be available for up to three years.

vii. *Health Plan Management Reports* – Provide Client with periodic Health Plan Management Reports and Managed Care Reports.

c. "Documentation" means the User Guidelines manual which Company makes available to Client.

d. "Member" means a person who meets the eligibility requirements of the Plan and is enrolled for coverage under the Plan.

3. **Client's Responsibilities and Use of the Plan Administration Site**

a. Client is responsible, notwithstanding any transfer of rights to the Client's broker, for performing all functions that the Plan Administration Site performs in order to administer the Plan, including but not limited to the following:

(1) Acquisition and maintenance of completed, executed and accurate enrollment applications for every eligible Member; and

(2) Updating information regarding all Members including, but not limited to, recording changes for name, beneficiary, benefits or primary care physicians, within 3 business days from the Client's receipt of notice or change.

b. The Client shall be responsible, notwithstanding any transfer of rights to the Client's broker, for reimbursing the Company for any claims paid by the Company on behalf of a terminated Member where the Client failed to timely update the Plan Administration Site and remove the Member therefrom.

c. The Company is relieved of any duties imposed upon it under other terms of this Contract to the extent those duties can be performed by the Plan Administration Site.

d. The Plan Administration Site may be used only to administer the Plan. With the Company's prior consent, the Client may subcontract, delegate or assign its rights or duties related to the Plan Administration Site, or allow a third party "read only access" to the Client's data on the Plan Administration Site. In this event, the following terms apply:

(1) The Client shall retain ultimate responsibility for all duties and obligations under the Contract. Any third party shall be subject to such duties and obligations. The Client shall be responsible for monitoring and overseeing the performance of any third party, any breach by a third party of such duties and obligations, and the Client indemnification provisions under the Contract shall apply to any such breach by a third party.

(2) The Company shall have no obligations to any third party, nor any liability for Plan Administration Site services performed by any third party.

e. Except for applications commonly known as web browser software, Client agrees not to use any software, program, application or any other device to access or log on to Company's computer systems or website or to automate the process of obtaining, downloading, transferring or transmitting any content or information to or from Company's computer systems or website.

f. Client acknowledges that electronic communications may be accessed by unauthorized third parties when communicated between Client and Company using the Internet, and agrees to use software produced by third parties, including but not limited to what is commonly known as web browser software that supports a data security protocol compatible with the protocol used by Company. Client agrees that Company is not responsible for notifying it of any upgrades, fixes or enhancements to any such software.

g. Company shall issue Client at least one unique user ID and password to enable use of the Plan Administration Site. Company shall issue Client additional unique user IDs and passwords to (i) enable additional employees of Client to make use of the Plan Administration Site and (ii) replace user IDs and passwords assigned to individuals who leave Client's employ or whose job duties no longer require use of the Plan Administration Site. Where applicable, Company will enable Members to create individual unique

user IDs, and Company will issue each Member a unique password. Client shall immediately notify Company when any of its employees to whom a user ID and password was issued terminates his or her employment or is transferred to a position that does not require use of the Plan Administration Site. Client agrees not hold Company liable for any damages of any kind resulting from Client's decision to disclose its user ID or password to any third party. Client agrees to immediately notify Company (i) if it becomes aware of any loss or theft or unauthorized use of Client's user ID or password or any unauthorized use of the Plan Administration Site.

h. Any use of the Plan Administration Site by Client, Client's employees or Members is subject to the Terms of Use, Privacy and Security Notice, and Legal Notice posted on the Company's website, as may be modified from time to time. Any failure by Client, Client's employees or Members to comply with the provisions of this Section 3 shall be a material breach of this Contract and may constitute misappropriation of Company's intellectual property rights. Client shall assume all responsibility and liability, including the use of the Plan Administration Site by Client's employees or Members.

i. Client acknowledges and agrees that any violation of any term, condition or provision of this Section 3 would cause Company irreparable harm for which there would be no adequate remedy at law, and that Company shall be entitled to preliminary and other injunctive relief against any such violation. Such injunctive relief shall be in addition to, and in no way shall limit, any other rights or remedies which Company may have at law or in equity including, but not limited to, damages.

j. Company may, in its sole discretion, suspend or terminate access to the Plan Administration Site by Client, Client's employees or any Member who violates any term, condition or provision of this Section 3. Such suspension or termination of access shall not entitle Client, Client's employees, Member, or any other person to any compensation or damages of any kind.

4. **Data Accuracy; Confidentiality; Proprietary Information**

a. Client acknowledges that Company will rely on the Data Client submits to Company through use of the Plan Administration Site for the purposes of maintaining records of Members' eligibility and underwriting, and administering the provisions of the Plan. Client hereby warrants that the Data it submits to Company through its use of the Plan Administration Site shall be complete and factually accurate in all respects, shall conform to and be consistent with the Plan's terms and shall be sufficient to enable Company to accurately calculate premium and/or other fees due in connection with the Plan. In particular, Client warrants that individual persons will be enrolled and disenrolled in strict accordance with the eligibility and other applicable provisions of the Plan.

b. Client acknowledges that the Plan Administration Site is a confidential and proprietary product and process, that it embodies valuable trade secrets, and that Company has certain intellectual property rights in and to the Plan Administration Site. Client acknowledges that no right, title or interest, except for the limited license set forth herein, is conveyed or transferred to Client by this Contract.

c. Client on its own behalf and on behalf of its Members agrees to indemnify and hold Company and its officers, directors, shareholders, employees and agents harmless pursuant to Section 6 of the Contract for Client's providing or failing to provide Data through Client's use of the Plan Administration Site, or Company's use of Data in reliance upon its accuracy and completeness and/or consistency with the Plan's provisions, or from Client's violation of any of the terms of this Appendix. These obligations shall survive the termination of this Appendix and/or the Administrative Services Contract.

5. **Support Services**

The Company will provide basic technical assistance regarding the Plan Administration Site via telephone, facsimile and electronic mail during the Company's regular business hours. The Plan Administration Site is accessible via computer transmissions for use on compatible personal, home or business computers, including Internet appliances with modems and network computers. Client agrees that it is solely responsible for procuring, installing and maintaining the technology, including Internet access, and all related long distance charges, if any, it uses to access the Plan Administration Site. Company shall have no liability for any service difficulties resulting from Client's failure to possess and correctly utilize technology adequate to use the Plan Administration Site, or for telephone, cable or satellite television, or Internet

service provider failures. The Company shall not be required to provide any software or systems support not expressly provided for herein.

6. **Limited Warranties**

   a. For the term of this license, Company warrants that the Plan Administration Site will perform substantially in accordance with Company's specifications when properly accessed. Company's warranty obligations under this Appendix are specifically and expressly limited to providing access to and the proper function of the Plan Administration Site. There is no warranty of merchantability, no warranty of fitness for a particular use and no warranty of non-infringement. There is no other warranty of any kind, express or implied, regarding the information or any aspect of the Plan Administration Site, including but not limited to information access.

   b. Data transmitted through the Plan Administration Site will to the extent required comply with the Standards for Electronic Data Interchange approved by the Department of Health and Human Services.

7. **Limitation of Liabilities**

   Notwithstanding anything to the contrary in the Administrative Services Contract, under no circumstances shall Company be liable to Client, its employees or its Members for damages of any kind, whether arising in tort, contract, negligence, strict products liability, statutory or regulatory violation or any other legal theory, in connection with or in any way arising out of Company's provision of the Plan Administration Site to Client.

8. **Termination**

   a. This Appendix may be terminated at any time upon fifteen (15) days prior written notice by Company to Client. In addition, this Appendix shall terminate automatically at the time:

      i. the Administrative Services Contract ends;

      ii. the Plan terminates;

      iii. the Company no longer insures or administers the Plan;

      iv. Client commits a material breach of this Appendix or defaults in the performance of any of its duties or obligations under this Appendix and such breach or default continues for a period of fifteen (15) days after Company gives Client written notice specifying the nature of the breach or default.

   b. The Plan Administration Site online services may terminate, in the sole discretion of the Company, upon discontinuation of the Plan Administration Site product.

HIPAA PRIVACY APPENDIX

To be attached to and made a part of the Administrative Services Contract

Effective January 01, 2023

By and between

Clear Creek County on behalf of the Plan

and

CIGNA HEALTH AND LIFE INSURANCE COMPANY

I. GENERAL PROVISIONS

Section 1. Effect. As of the Effective Date, the terms and provisions of this Appendix are incorporated in and shall supersede any conflicting or inconsistent terms and provisions of (as applicable) the Administrative Services Contract and/or Flexible Spending Account or Reimbursement Accounts Administrative Services Agreement to which this Appendix is attached, including all exhibits or other attachments to, and all documents incorporated by reference in, any such applicable agreements (individually and collectively any such applicable agreements are referred to as the "**Agreement**"). This Appendix sets out terms and provisions relating to the use and disclosure of Protected Health Information ("**PHI**") without written authorization from the Individual.

Section 2. Amendment to Comply with Law. Cigna Health and Life Insurance Company, Client (also referred to as "**Plan Sponsor**") and the group health plan that is the subject of the Agreement (also referred to as the "**Plan**") agree to amend this Appendix to the extent necessary to allow either the Plan or Cigna Health and Life Insurance Company to comply with applicable laws and regulations including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 and its implementing Administrative Simplification regulations (45 C.F.R. Parts 142, 160, 162 and 164) ("**HIPAA**"), also known as the HIPAA Standards for Electronic Transactions, the HIPAA Security Standards, and the HIPAA Privacy Rule; the Health Information Technology for Economic and Clinical Health Act, which was included in the American Recovery and Reinvestment Act of 2009 (P.L. 111-5 ("**ARRA**")) and its implementing regulations and guidance ("**HITECH**").

Section 3. Relationship of Parties. The parties intend that Cigna Health and Life Insurance Company is an independent contractor and not an agent of the Plan.

II. PERMITTED USES AND DISCLOSURES BY CIGNA HEALTH AND LIFE INSURANCE COMPANY

Section 1. Disclosures Generally. Except as otherwise provided in this Appendix, Cigna Health and Life Insurance Company may use or disclose PHI to perform functions, activities, or services for, or on behalf of, the Plan as specified in the Agreement, provided that such use or disclosure would not violate the HIPAA Privacy & Security Rules if done by the Plan.

Section 2. To Carry Out Plan Obligations. To the extent Cigna Health and Life Insurance Company is to carry out one or more of the Plan's obligations under Subpart E of 45 CFR Part 164, Cigna Health and Life Insurance Company agrees to comply with the requirements of Subpart E that apply to the Plan in the performance of such obligations.

Section 3. Management & Administration.

(A) Cigna Health and Life Insurance Company may use PHI for the proper management and administration of Cigna Health and Life Insurance Company or to carry out the legal responsibilities of Cigna Health and Life Insurance Company.

(B) Cigna Health and Life Insurance Company may disclose PHI for the proper management and administration of Cigna Health and Life Insurance Company, provided that disclosures are: (a) required by law or (b) Cigna Health and Life Insurance Company obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it is disclosed to the person, and the person notifies Cigna Health and Life Insurance Company of any instances of which it is aware in which the confidentiality of the information has been breached.

(C) Except as otherwise limited in this Appendix, Cigna Health and Life Insurance Company may use PHI to provide Data Aggregation services relating to the healthcare operations of the Plan or to de-identify PHI. Once information is de-identified, this Appendix shall not apply.

Section 4. Required By Law. Cigna Health and Life Insurance Company may use or disclose PHI as required by law.

III. OTHER OBLIGATIONS AND ACTIVITIES OF CIGNA HEALTH AND LIFE INSURANCE COMPANY

Section 1. Receiving Remuneration in Exchange for PHI Prohibited. Cigna Health and Life Insurance Company shall not directly or indirectly receive remuneration in exchange for any PHI of an Individual, unless an authorization is obtained from the Individual, in accordance with 45 C.F.R. §164.508, that specifies whether PHI can be exchanged for remuneration by the entity receiving PHI of that individual, unless otherwise permitted under the HIPAA Privacy Rule.

Section 2. Limited Data Set or Minimum Necessary Standard and Determination. Cigna Health and Life Insurance Company shall, to the extent practicable, limit its use, disclosure, or request of Individuals' PHI to the minimum necessary amount of Individuals' PHI to accomplish the intended purpose of such use, disclosure, or request and to perform its obligations under the underlying Agreement and this Appendix. Cigna Health and Life Insurance Company shall determine what constitutes the minimum necessary to accomplish the intended purpose of such disclosure. Cigna Health and Life Insurance Company's obligations under this Section 3 shall be subject to modification to comply with future guidance to be issued by the Secretary.

Section 3. Security Standards. Cigna Health and Life Insurance Company shall use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to Electronic PHI to prevent use or disclosure of PHI other than as provided for by the Agreement.

Section 4. Protection of Electronic PHI. With respect to Electronic PHI, Cigna Health and Life Insurance Company shall:

(A) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that Cigna Health and Life Insurance Company creates, receives, maintains, or transmits on behalf of the Plan as required by the Security Standards;

(B) Ensure that any agent, including a subcontractor, to whom Cigna Health and Life Insurance Company provides Electronic PHI agrees to implement reasonable and appropriate safeguards to protect such information; and,

(C) Report to the Plan any Security Incident of which it becomes aware.

Section 5. Reporting of Violations. Cigna Health and Life Insurance Company shall report to the Plan any use or disclosure of PHI not provided for by this Appendix of which it becomes aware. Cigna Health and Life Insurance Company agrees to mitigate, to the extent practicable, any harmful effect from a use or disclosure of PHI in violation of this Appendix of which it is aware.

Section 6. Security Breach Notification. Cigna Health and Life Insurance Company will notify the Plan of a Breach (including privacy related incidents that might, upon further investigation, be deemed to be a Breach) without unreasonable delay and, in any event, within ten business days after Cigna Health and Life Insurance Company's discovery of same. This notification will include, to the extent known:

i. the names of the individuals whose PHI was involved in the Breach;

ii. the circumstances surrounding the Breach;

iii. the date of the Breach and the date of its discovery;

iv. the information Breached;

v. any steps the impacted individuals should take to protect themselves;

vi. the steps Cigna Health and Life Insurance Company is taking to investigate the Breach, mitigate losses, and protect against future Breaches; and,

vii. a contact person who can provide additional information about the Breach.

For purposes of discovery and reporting of Breaches, Cigna Health and Life Insurance Company is not the agent of the Plan or the Client (as "agent" is defined under common law). Cigna Health and Life Insurance Company will investigate Breaches, assess their impact under applicable state and federal law, including HITECH, and make a recommendation to the Plan as to whether notification is required pursuant to 45 C.F.R. §§164.404-408 and/or applicable state breach notification laws. With the Plan's prior approval, Cigna Health and Life Insurance Company will issue notices to such individuals, state and federal agencies - including the Department of Health and Human Services, and/or the media as the Plan is required to notify pursuant to, and in accordance with the requirements of applicable law (including 45 C.F.R. §§164.404-408). Cigna Health and Life Insurance Company will pay the costs of issuing notices required by law and other remediation and mitigation which, in Cigna Health and Life Insurance Company's discretion, are appropriate and necessary to address the Breach. Cigna Health and Life Insurance Company will not be required to issue notifications that are not mandated by applicable law. Cigna Health and Life Insurance Company shall provide the Plan with information necessary for the Plan to fulfill its obligation to report Breaches affecting fewer than 500 Individuals to the Secretary as required by C.F.R. §164.408(c).

Section 7. Disclosures to and Agreements by Third Parties. In accordance with 45 CFR §164.502(e)(1)(ii) and 164.308(b)(2), Cigna Health and Life Insurance Company agrees to ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of Cigna Health and Life Insurance Company agree to the same restrictions, conditions, and requirements that apply to Cigna Health and Life Insurance Company with respect to such information.

Section 8. Access to PHI. Cigna Health and Life Insurance Company shall provide an Individual with access to such Individual's PHI contained in a Designated Record Set in response to such Individual's request in the manner and time required in 45 C.F.R. §164.524.

Section 9. Availability of PHI for Amendment. Cigna Health and Life Insurance Company shall respond to a request by an Individual for amendment to such Individual's PHI contained in a Designated Record Set in the manner and time required in 45 C.F.R. §164.526, except that the Plan shall handle any requests for amendment of PHI originated by the Plan, Plan Sponsor or the Plan's other business associates, such as enrollment information.

Section 10. Right to Confidential Communications and to Request Restriction of Disclosures of PHI. Cigna Health and Life Insurance Company shall comply with, and shall assist the Plan in complying with, responding to Individuals' requests for confidential communications or to restrict the uses and disclosures of their PHI under 45 C.F.R. §164.522. This shall include complying with requests to restrict the disclosure of certain PHI with which the Plan is required to agree, in accordance with 45 C.F.R. §164.522.

Section 11. Accounting of PHI Disclosures. Cigna Health and Life Insurance Company shall provide an accounting of disclosures of PHI to an Individual who requests such accounting in the manner and time required in 45 C.F.R. §164.528.

Section 12. Processes and Procedures. In carrying out its duties set forth in Article II, Sections 8 – 11, above, Cigna Health and Life Insurance Company will implement the Standard Business Associate Processes and Procedures (the "Processes and Procedures") attached hereto for requests from Individuals, including the requirement that requests be made in writing, the creation of forms for use by Individuals in making such requests, and the setting of time periods for the Plan to forward to Cigna Health and Life Insurance Company any such requests made directly to the Plan or Plan Sponsor. In addition, Cigna Health and Life Insurance Company will implement the Processes and Procedures relating to disclosure of PHI to Plan Sponsor or designated third parties.

Section 13. Availability of Books and Records. Cigna Health and Life Insurance Company hereby agrees to make its internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by Cigna Health and Life Insurance Company on behalf of the Plan, available to the Secretary for purposes of determining the Plan's compliance with the Privacy Rule.

IV. TERMINATION OF AGREEMENT WITH CIGNA HEALTH AND LIFE INSURANCE COMPANY

Section 1. Termination Upon Breach of Provisions Applicable to PHI. Any other provision of the Agreement notwithstanding, the Agreement may be terminated by the Plan upon prior written notice to Cigna Health and Life Insurance Company in the event that Cigna Health and Life Insurance Company materially breaches any obligation of this Appendix and fails to cure the breach within such reasonable time as the Plan may provide for in such notice; provided that in the event that termination of the Agreement is not feasible, in the Plan's sole discretion, the Plan shall have the right to report the breach to the Secretary.

If Cigna Health and Life Insurance Company knows of a pattern of activity or practice of the Plan that constitutes a material breach or violation of the Plan's duties and obligations under this Appendix, Cigna Health and Life Insurance Company shall provide a reasonable period of time, as agreed upon by the parties, for the Plan to cure the material breach or violation. Provided, however, that, if the Plan does not cure the material breach or violation within such agreed upon time period, Cigna Health and Life Insurance Company may terminate the Agreement at the end of such period.

Section 2. Use of PHI upon Termination. The parties hereto agree that it is not feasible for Cigna Health and Life Insurance Company to return or destroy PHI at termination of the Agreement; therefore, the protections of this Appendix for PHI shall survive termination of the Agreement, and Cigna Health and Life Insurance Company shall limit any further uses and disclosures of such PHI to the purpose or purposes which make the return or destruction of such PHI infeasible.

V. OBLIGATION OF THE PLAN

The Plan will not request Cigna Health and Life Insurance Company to use or disclose PHI in any manner that would not be permissible under HIPAA or HITECH if done by the Plan.

VI. DEFINITIONS FOR USE IN THIS APPENDIX

Definitions. Certain capitalized terms used in this Appendix shall have the meanings ascribed to them by HIPAA and HITECH including their respective implementing regulations and guidance. If the meaning of any term defined herein is changed by regulatory or legislative amendment, then this Appendix will be modified automatically to correspond to the amended definition. All capitalized terms used herein that are not otherwise

defined have the meanings described in HIPAA and HITECH. A reference in this Appendix to a section in the HIPAA Privacy Rule, HIPAA Security Rule, or HITECH means the section then in effect, as amended.

"**Breach**" means the unauthorized acquisition, access, use, or disclosure of Unsecured PHI which compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information. A Breach does not include any unintentional acquisition, access, or use of PHI by an employee or individual acting under the authority of Cigna Health and Life Insurance Company if such acquisition, access, or use was made in good faith and within the course and scope of the employment or other professional relationship of such employee or individual with Cigna Health and Life Insurance Company; any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by Cigna Health and Life Insurance Company to another similarly situated individual at the same facility; and such information is not further acquired, accessed, used, or disclosed without authorization by any person.

"Business Associate" means Cigna Health and Life Insurance Company.

"Covered Entity" means Plan.

"**Designated Record Set**" shall have the same meaning as the term "designated record set" as set forth in the Privacy Rule, limited to the enrollment, payment, claims adjudication, and case or medical management record systems maintained by Cigna Health and Life Insurance Company for the Plan, or used, in whole or in part, by Cigna Health and Life Insurance Company or the Plan to make decisions about Individuals.

"**Effective Date**" shall mean the earliest date by which the Plan is required to have executed a Business Associate Agreement with Cigna Health and Life Insurance Company pursuant to the requirements of applicable law.

"**Electronic Protected Health Information**" shall mean PHI that is transmitted by or maintained in electronic media as that term is defined in 45 C.F.R. §160.103.

"**Limited Data Set**" shall have the same meaning as the term "limited data set" as set forth in as defined in 45 C.F.R. §164.514(e)(2).

"**Protected Health Information**" or "**PHI**" shall have the same meaning as set forth at C.F.R. §160.103.

"**Secretary**" shall mean the Secretary of the United States Department of Health and Human Services.

"**Security Incident**" shall have the same meaning as the term "security incident" as set forth in 45 C.F.R. §164.304.

"**Unsecured Protected Health Information**" shall mean PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued under Section 13402(h)(2) of ARRA.

Cigna Health and Life Insurance Company
Standard Business Associate Processes and Procedures

These Standard Business Associate Processes and Procedures apply to each self-funded group benefit plan ("Plan") of an entity ("Plan Sponsor") that has entered or will enter into an Administrative Services Contract, Flexible Spending Account or Reimbursement Accounts Administrative Services Agreement and/or Continuation Coverage Services Agreement (collectively, as applicable, the "Administrative Services `Agreement") with Cigna Health and Life Insurance Company ("Cigna Health and Life Insurance Company"). The Plan and Cigna Health and Life Insurance Company are parties to a Business Associate Agreement/Privacy Appendix. Unless otherwise defined, capitalized terms have the meaning provided therein, or if not defined in such agreement, as defined in 45 C.F.R. parts 142, 160, 162 and 164 ("HIPAA"), also known as the HIPAA Standards for Electronic Transactions, the HIPAA Security Standards, and the HIPAA Privacy Rule and/or the Health Information Technology for Economic and Clinical Health Act, which was included in the American Recovery and Reinvestment Act of 2009 (P.L. 111-5 ("ARRA")).

Section 1. Access to PHI. When an Individual requests access to PHI contained in a Designated Record Set and such request is made directly to the Plan or Plan Sponsor, the Plan shall forward the request to Cigna Health and Life Insurance Company within five (5) business days of such receipt. Upon receipt of such request from the Plan, or upon receipt of such a request directly from an Individual, Cigna Health and Life Insurance Company shall make such PHI available directly to the Individual within the time and manner required in 45 C.F.R. §164.524. The Plan delegates to Cigna Health and Life Insurance Company the duty to determine, on behalf of the Plan, whether to deny access to PHI requested by an Individual and the duty to provide any required notices and review in accordance with the HIPAA Privacy Rule.

Section 2. Availability of PHI for Amendment.

(a) When an Individual requests amendment to PHI contained in a Designated Record Set, and such request is made directly to the Plan or Plan Sponsor, within five (5) business days of such receipt, the Plan shall forward such request to Cigna Health and Life Insurance Company for handling, except that the Plan shall retain and handle all such requests to the extent that they pertain to Individually Identifiable Health Information (such as enrollment information) originated by the Plan, Plan Sponsor, or the Plan's other business associates. Cigna Health and Life Insurance Company shall respond to such forwarded requests as well as to any such requests that it receives directly from Individuals as required by 45 C.F.R. §164.526, except that Cigna Health and Life Insurance Company shall forward to the Plan for handling any requests for amendment of PHI originated by the Plan, Plan Sponsor, or the Plan's other business associates.

(b) With respect to those requests handled by Cigna Health and Life Insurance Company under subparagraph (a) above, the Plan delegates to Cigna Health and Life Insurance Company the duty to determine, on behalf of the Plan, whether to deny a request for amendment of PHI and the duty to provide any required notices and review as well as, in the case of its determination to grant such a request, the duty to make any amendments in accordance with the terms of the Privacy Rule. In all other instances, the Plan retains all responsibility for handling such requests, including any denials, in accordance with the HIPAA Privacy Rule.

(c) Whenever Cigna Health and Life Insurance Company is notified by the Plan that the Plan has agreed to make an amendment pursuant to a request that it handles under subparagraph (a) above, Cigna Health and Life Insurance Company shall incorporate any such amendments in accordance with 45 C.F.R. §164.526.

Section 3. Accounting of Disclosures. When an Individual requests an accounting of disclosures of PHI held by Cigna Health and Life Insurance Company directly to the Plan or Plan Sponsor, the Plan shall within five (5) business days of such receipt forward the request to Cigna Health and Life Insurance Company to handle. Cigna Health and Life Insurance Company shall handle such requests, and any such requests for an accounting of disclosures received directly from Individuals, in the time and manner as required in 45 C.F.R. §164.528.

Section 4. Requests for Confidential Communications or to Restrict Disclosure of PHI. Cigna Health and Life Insurance Company shall handle Individuals' requests made to it for privacy protection for PHI in Cigna Health and Life Insurance Company's possession pursuant to the requirements of 45 C.F.R. §164.522. The Plan shall forward to Cigna Health and Life Insurance Company to handle any such requests the Plan receives from Individuals that affect PHI held by Cigna Health and Life Insurance Company.

Section 5. General Provisions Regarding Requests. Cigna Health and Life Insurance Company may require that requests pursuant to Sections 1 through 4 above be made in writing and may create forms for use by Individuals in making such requests. When responding to an Individual's request as provided above, Cigna Health and Life Insurance Company may inform the Individual that there may be other "protected health information" created or maintained by the Plan and/or the Plan's other business associates and not included in the Cigna Health and Life Insurance Company's response. Cigna Health and Life Insurance Company shall not be responsible for performing any duties described in the Business Associate Agreement with respect to any such other "protected health information." In carrying out its duties set forth herein, Cigna Health and Life Insurance Company may establish such additional procedures and processes for requests from Individuals as permitted by the Privacy Rule.

Section 6. Disclosure of PHI to the Plan Sponsor. To the extent that the fulfillment of Cigna Health and Life Insurance Company's obligations under the Administrative Services Agreement requires Cigna Health and Life Insurance Company to disclose or provide access to PHI to Plan Sponsor or any person under the control of Plan Sponsor (including third parties), Cigna Health and Life Insurance Company shall make such disclosure of or provide such access to PHI only as follows:

(i) Cigna Health and Life Insurance Company shall disclose Summary Health Information to any employee or other person under the control of Plan Sponsor (including third parties) upon the Plan Sponsor's written request for the purpose of obtaining premium bids for the provision of health insurance or HMO coverage for the Plan or modifying, amending or terminating the Plan; and

(ii) If the Plan elects to provide PHI to the Plan Sponsor, Cigna Health and Life Insurance Company shall disclose or make available PHI, other than Summary Health Information, at the written direction of the Plan to only those employees or other persons that Plan Sponsor represents are identified in the Plan documents and under the control of Plan Sponsor solely for the purpose of carrying out the Plan administration functions that Plan Sponsor performs for the Plan. Where requested by Cigna Health and Life Insurance Company, such employees or other persons (including third parties) will be identified by the Plan in writing (by name, title, or other appropriate designation) to Cigna Health and Life Insurance Company as a condition of disclosure of PHI pursuant to this Section 6(ii). The Plan may modify such list from time to time by written notice to Cigna Health and Life Insurance Company.

Section 7. Disclosures of PHI to Third Parties. Upon the Plan's written request, Cigna Health and Life Insurance Company will provide PHI to certain designated third parties who assist in administering the Plan and who are authorized by the Plan to receive such information solely for the purpose of assisting in carrying out Plan administration functions ("Designated Third Parties"). Such parties may include, but are not limited to, third-party administrators, consultants, brokers, auditors, successor administrators or insurers, and stop-loss carriers. As a condition to providing PHI to a Designated Third Party, Cigna Health and Life Insurance Company may require that the Plan have a business associate agreement (within the meaning of the Privacy Rule) with such Designated Third Party.

Claim Audit Agreement (Sample)

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

B. WHEREAS, ________________("Auditor") has been retained by Client for the purpose of performing an audit ("Audit") of claims administered by COMPANY;

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

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

1. Audit Specifications

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

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

2. Review of Specifications

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

3. Access to Information

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

4. Audit Report

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

5. Comment on Audit Report

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

6. Confidentiality

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

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

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

7. Restricted Use of the Audit Information

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

8. Termination

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

Cigna Health and Life Insurance Company

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: ___________________________

Title: _________________________________

Date: _________________________________

Client: _________________________

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: ____________________________

Title: _________________________________

Date: _________________________________

Auditor: __________________________

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: ___________________________

Title: _________________________________

Date: ___________________________________

PHARMACY HEALTH LIVING GUARANTEE PROGRAM - APPENDIX

CHLIC agrees to provide Employer with the Pharmacy Healthy Living Guarantee Program as set forth below. CHLIC guarantees Employer that CHLIC will meet or exceed each of the performance guarantees listed below, subject to the terms and conditions set forth herein. The measurement and assessment of each of the performance guarantees shall be based on CHLIC's then-current standard performance guarantee program measurement processes and protocols. CHLIC may remove for guarantee calculation purposes Members residing in zip codes subject to a natural disaster as identified by a state or federal declaration of a state of emergency during the applicable performance guarantee measurement period. If CHLIC fails to meet any one of the applicable performance guarantees, then CHLIC will provide Employer the applicable performance guarantee payment amount as follows:

1 For Client Specific Performance Guarantees, CHLIC will provide Employer the Performance Guarantee payment amount due and owing, if any, within 180 days from the end of Employer's Plan Year; and

2 For CHLIC Book of Business Performance Guarantees, CHLIC will provide Employer the Performance Guarantee payment amount due and owing, if any, within 180 days from the end of the applicable calendar year.

In addition to the Conditions Precedent set forth in this Performance Guarantee Agreement, the additional conditions shall apply: (1) Employer must be under contract with CHLIC for the provision of administrative services for Employer's integrated medical and prescription drug benefits plan, and (2) Employer must remain a CHLIC pharmacy benefit service client for the full term of its Agreement with CHLIC, and (3) Employer must remain and be current in all of its payment obligations due and owing under its services agreement with CHLIC, and (4) for the Client Specific Measurement Performance Guarantees, CHLIC must have administered Employer's pharmacy benefit for at least one full year immediately prior to the guarantee period, and (5) for the Book of Measurement Adherence Performance Guarantees, CHLIC must have administered Employer's pharmacy benefit and have available to CHLIC at least one full year of applicable Employer pharmacy benefit design and claim data. If Employer fails to meet any one or more of the foregoing conditions, then the Pharmacy Healthy Living Guarantee Program shall be null and void and of no effect, and CHLIC shall have no obligation to Employer under this Performance Guarantee Program, including but not limited to having no obligation to provide Employer with any performance standard payment amount under this Performance Guarantee program.

For purposes of this Pharmacy Healthy Living Guarantee Program, the following terms of use shall apply:

1. "Adherent" or "Adherence Rate" means a PDC score of 80% or more.
2. "Book of Business Measurement" means the performance guarantee is determined based on data for the applicable CHLIC aggregate book of business measured in accordance with the Performance Standard program, and not on an Employer or Member only basis.
3. "CHLIC National Average Cost" means the average cost for the applicable event based on CHLIC's applicable book of business database for the calendar year immediately preceding the commencement of the Guarantee Period.
4. "Non-Adherent" or "Non-adherence Rate" means a PDC score of less than 80%.
5. "PDC Score" means the applicable percentage of Proportion of Days Covered (PDC) as determined using the methodology as defined by the Pharmacy Quality Alliance (PQA) to measure adherence.
6. "PEPM" means per employee per month calculated as the total number of primary eligible members enrolled in Employer's plan as of the first day of the applicable Plan Year and who remain a participating member during the entire Plan Year.
7. "Client Specific Measurement" means the performance guarantee is determined on based on data that is specific to Employer and its Members in accordance with the Performance Standard program, and not on a CHLIC aggregate book of business basis.

CHLIC reserves the right to revise, modify, or discontinue the Pharmacy Healthy Living Guarantee Program.

Select Segment Pharmacy Healthy Living Program Guarantees

1. **Asthma: Avoidance of Emergency Room/Hospitalization (Client Specific Measurement)**

1.1. Guarantee - CHLIC guarantees Employer that if a Qualifying Asthma Member experiences an emergency room visit and/or is admitted for a hospital stay due to an asthma event during the Guarantee Year, then CHLIC will credit Employer the CHLIC National Average Cost for such emergency room and/or hospital admission in accordance with this Performance Guarantee program, limited to one reimbursement per applicable event per Member lifetime.

1.2. "Qualifying Asthma Member" means a member who: (1) was a participating member under Employer's plan for the entire Plan Year, (2) was Adherent in the taking of their asthma medications, and (3) was over 18 years of age.

2. **Cholesterol: (Drug Cost Reimbursement for Member Heart Attack)(Client Specific Measurement)**

2.1. Guarantee - CHLIC guarantees that if any Qualifying Cholesterol Member experiences one or more heart attacks during the Plan Year, then CHLIC will reimburse Employer the CHLIC National Average Cost for one 12-month Cholesterol lowering drug medication therapy in accordance with this Performance Guarantee program, reimbursement limited to one event per Member lifetime.

2.2. "Qualifying Cholesterol Member" means a member who: (1) was a participating member under Employer's plan for the entire Plan Year, (2) was Adherent in the taking of their cholesterol medications, and (3) is over 18 years of age.

3. **Gap in Care All-In: Closure Rate (Applicable Book of Business Measurement)**

3.1. CHLIC guarantees a 16% gap closure rate due to the Well-Informed Program during the applicable calendar year in accordance with CHLIC's Performance Guarantee program. If CHLIC fails to achieve at least a 16% gap closure rate due to the Well-Informed Program as measured on an applicable book of business basis, then CHLIC will credit Employer the amount of $0.06 PEPM in accordance with this Performance Guarantee program. If Employer's Plan Year commences on a date other than January 1, then the Performance Guarantee payment amount due and owing, if any, will be calculated on a pro-rated basis based on Employer's actual Plan Year start date.

4. **Diabetes: Improved Adherence Rate (Applicable Book of Business Measurement)**

4.1. Guarantee - CHLIC guarantees a 38% improvement in the Adherence Rate of Qualifying Non-Adherent Diabetes Members for the applicable calendar year in accordance with CHLIC's Performance Guarantee program. If CHLIC fails to improve the Adherence Rate of Qualifying Non-Adherent Diabetes Members in the taking of their applicable diabetes medication by at least 38% by the end of the applicable calendar year, as measured on an applicable book of business basis, then CHLIC will credit Employer the amount of $0.06 PEPM in accordance with CHLIC's Performance Guarantee program. If Employer's Plan Year commences on a date other than January 1, then the Performance Guarantee payment amount due and owing, if any, will be calculated on a pro-rated basis based on Employer's actual Plan Year start date.

5. **Cardiovascular: Improved Adherence Rate (Applicable Book of Business Measurement)**

5.1. Guarantee - CHLIC guarantees a 40% improvement in the Adherence Rate of Qualifying Non-Adherent Cardiovascular Members in the taking of their applicable cardiovascular medication for the applicable calendar year in accordance with CHLIC's Performance Guarantee program. If CHLIC fails to improve

the Adherence Rate of Qualifying Non-Adherent Cardiovascular Members in the taking of applicable cardiovascular medication by at least 40% for the applicable calendar year, as measured on an applicable book of business basis, then CHLIC will credit Employer the amount of $0.06 PEPM in accordance with CHLIC's Performance Guarantee program. If Employer's Plan Year commences on a date other than January 1, then the Performance Guarantee payment amount due and owing, if any, will be calculated on a pro-rated basis based on Employer's actual Plan Year start date.