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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

DANIEL KREUTZMANN, Individually and On Behalf of All Others Similarly Situated,

Plaintiff,

vs.

CIGNA HEALTH AND LIFE INSURANCE COMPANY,

Defendant.

Case No.: **'26CV5836 CAB BJW**

CLASS ACTION COMPLAINT FOR VIOLATIONS OF 29 U.S.C. § 1001, *et seq.* ("ERISA")

JURY TRIAL DEMANDED

Pursuant to Fed. R. Civ. P. 23, Plaintiff Daniel Kreutzmann brings this class action against Defendant Cigna Health and Life Insurance Company ("Cigna") on behalf of himself and all other persons within the United States (the "Class") who have been balance billed for out-of-network ground ambulance services provided to them while they were participants in, or beneficiaries of, an employer-sponsored health plan administered by Cigna, under an Administrative Services Only agreement between Cigna and the employer.

Plaintiff makes the following allegations based upon personal knowledge as to himself and his own acts and experiences, and based upon the investigation of his counsel as to all other matters. Plaintiff and his counsel believe that substantial, additional evidentiary support will exist for the allegations set forth herein after a reasonable opportunity for discovery.

INTRODUCTION

1. Millions of Americans earn personal healthcare coverage through their employment, under employee health plans sponsored by their employers. Cigna is a leading, third-party administrator of large companies' employee health plans in the United States.

2. Cigna administers employee health plans under Administrative Services Only ("ASO") agreements with corporate employers. Employers contract with Cigna to structure their health plans and process their employees' healthcare claims. Under the corporate health plans that are the subject of this action, Cigna runs the plans' day-to-day operations (*i.e.,* drafts plan documents, processes healthcare claims, and makes coverage determinations), while each employer pays for its employees' covered healthcare costs.

3. "Self-funded" corporate health plans of this type are governed by the Employees' Retirement Income Security Act, 29 U.S.C. § 1001, *et seq.* ("ERISA"). As a health plan administrator under ERISA, Cigna must act as a fiduciary and

"discharge [its] duties with respect to a plan solely in the interest of the participants and beneficiaries" of the plan. 29 U.S.C. § 1104(a)(1). Cigna must act "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use." *Id.* In short, Cigna owes statutory, fiduciary duties of loyalty and reasonable care to all U.S. employees who earn healthcare coverage from their employers under the ERISA plans Cigna administers.

4. This case arises from Cigna's violation of its fiduciary duties, in its administration of claims for ground ambulance services provided to ERISA plan participants and beneficiaries.

5. Under the health plans Cigna administers, ground ambulance providers are "out-of-network." This means they have not contractually reduced the bills they send to Cigna for ambulance services provided to plan participants. When a covered employee needs ground ambulance care, the ambulance provider affords that patient all necessary care on the spot. Soon thereafter, the ambulance provider sends Cigna its unnegotiated invoice for services rendered. Ground ambulance providers' fees are generally limited by law, but they remain expensive: often several thousand dollars per ambulance incident, even for minimal, non-emergency services.

6. The plans Cigna administers cover many "out-of-network" health services, including ground ambulance services. This is because requiring covered patients to use only selected, "in-network" ambulance providers would be unsafe and impractical. If someone needs an ambulance, they typically lack the power and discretion to choose which ambulance provider arrives to help them. Accordingly, Cigna's plan documents and ASO agreements with employers provide that Cigna will "negotiate" out-of-network providers' fees, including ground ambulance fees, *after* the fact of care, ostensibly to reduce costs for corporate health plans and their covered employees.

7. Cigna, however, has a conflict of interest in its cost "negotiations" with ground ambulance providers. The conflict of interest arises from Cigna's standard ASO agreements with corporate employers. Under those agreements, Cigna earns contingency fees from plan-sponsoring employers, based on how far down Cigna "negotiates" ambulance providers' fees for services rendered to covered employees.

8. Whatever the difference might be between an ambulance provider's original, unnegotiated fee and the lower, Cigna-negotiated amount an employer ends up paying, Cigna earns up to 29% of that difference from the employer as a "cost containment fee" under its ASO agreements. Cigna, however, knows that ground ambulance providers directly "balance bill" patients for that same difference: for whatever portion of the original, unnegotiated ambulance charges the employer does *not* pay.

9. The net result is that Cigna itself earns more money as an ERISA plan administrator, when covered employees are billed more money for ground ambulance care. Cigna's 29% contingency fees create unnecessary, financial conflicts of interest between Cigna as a plan administrator, and covered employee-participants in the plans Cigna administers: particularly participants who end up needing an ambulance. With respect to such participants, Cigna exploits its conflict of interest and its role as their plan administrator, for its own benefit and to their known detriments.

10. As plan administrator, Cigna has significant influence if not control over the "negotiated" dollar amounts employers' health plans pay to ground ambulance providers on behalf of their covered employees. Cigna uses that control and influence to artificially *suppress* the amounts ERISA plans pay to ground ambulance providers on behalf of patients. By suppressing the dollar amounts plans pay for ambulance care, Cigna directly *increases* the contingency fees it receives from corporate employers. At the same time, Cigna knows its suppression of plan payments increases all the unpaid balances of original, unnegotiated ambulance fees, for which covered

employees become responsible. That creates a conflict of interest of a type that ERISA forbids, between Cigna as a plan administrator, and participants and beneficiaries of the health plans Cigna administers.

11. Due to Cigna's conflicted conduct as a plan fiduciary, Plaintiff and the Class have personally incurred and paid millions of dollars in ground ambulance charges, which they would not otherwise have incurred. By this action, Plaintiff seeks all appropriate statutory relief on behalf of himself and the putative Class.

PARTIES

12. Plaintiff Daniel Kreutzmann is a natural person residing in San Diego County, California. At all relevant times, he paid for and had personal health coverage through his employer's self-funded ERISA plan administered by Cigna.

13. Defendant Cigna Health and Life Insurance Company is a Delaware corporation with headquarters in Bloomfield, Connecticut. In addition to being a prominent health insurance company, Cigna serves as a third-party administrator of ERISA health plans sponsored and funded by large, corporate employers throughout the United States.

JURISDICTION AND VENUE

14. This Court has jurisdiction under 28 U.S.C. § 1331 and 29 U.S.C § 1132.

15. Venue is proper in this Court under 28 U.S.C. § 1391, as a substantial part of the events and omissions giving rise to Plaintiff's claims occurred in this District, and because Defendant has caused redressable harm to Plaintiff and other Class members within this District.

SUBSTANTIVE ALLEGATIONS

Background on "Self-Funded" ERISA Plans

16. Many corporate employers offer health coverage to their employees as a continuing benefit of employment. Employers offer to pay in full or substantial part for health services their employees receive from providers like physicians, hospitals,

therapists, and ambulance companies. The employees help pay for such coverage through their continuing service to their employers, and typically through periodic, cash deductions from their paychecks. Employer-funded health plans are called "self-funded" plans because the employer, rather than an insurance company, covers its own employees' healthcare costs.

17. Self-funded health plans are governed almost exclusively by ERISA. They function similarly to traditional health insurance policies, except that an uninsured employer, instead of an insurance company, assumes all the risks and obligations of paying for its employees' healthcare needs. Financially speaking, the employer acts much like a health insurer, and treats the employee-participants in its plan like insurance policyholders.

18. Most employers, however, do not specialize in the health insurance business. They have no competence or desire to structure insurance-like health plans, make coverage determinations, process medical claims, or deal with healthcare providers. Accordingly, they outsource the daily operations of their employee health plans to an established insurance company, such as Cigna.

19. Insurance companies like Cigna act as third-party administrators (or "TPAs") of corporate employers' self-funded health plans. TPAs design and operate all the back end, insurance-like functions of the employers' plans. TPAs structure and draft the governing plan documents, deal with covered employees and their healthcare providers, process claims, make coverage determinations, and facilitate employer payments to providers. TPAs create, interpret and apply employers' health plan terms, and tell the employers when, who and how much to pay for their employees' care.

20. ERISA expressly provides for this TPA framework. Under ERISA, self-funded health plans must be "established and maintained pursuant to a written instrument," which identifies "one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the

plan." 29 U.S.C. § 1101(a). Insurance companies exercise that authority as TPAs for corporate employers' ERISA plans, under "Administrative Services Only" (or "ASO") agreements with the employers.

Cigna's ASO Agreements With Corporate Employers

21. Cigna is a prominent third-party administrator of self-funded ERISA health plans in the United States. For many years, Cigna has executed standardized ASO agreements with numerous corporate employers, including publicly traded, multibillion-dollar corporations operating nationally and internationally.

22. Cigna's ASO Agreements with employers include provisions substantially similar to the following:

> While this Agreement is in effect, CHLIC as the party vested with discretionary claim authority shall, consistent with, the claim administration policies and procedures then applicable to its own health care insurance business (i) receive and review claims for Plan Benefits; (ii) determine the Plan Benefits, if any, payable for such claims; (iii) disburse payments of Plan Benefits to claimants; and (iv) provide in the manner and within the time limits required by Applicable Law, notification to claimants of (a) the coverage determination, including in the case of any adverse benefit determination, the specific reasons for the determination, the Plan provisions on which the determination is based and such other information as required under section 503 of ERISA, or (b) any anticipated delay in making a coverage determination beyond the time required by Applicable Law.

E.g., Ex. C at 5, § 2(a).[1]

[1] Defendant Cigna Health and Life Insurance Company refers to itself as "CHLIC" in its ASO Agreements with employers.

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

E.g., Ex. E at 5, § 2(c).

23. In short, Cigna singlehandedly runs company-sponsored employee health plans as a third-party administrator. This includes managing sizable bank accounts funded by large, corporate employers, to make payments to covered employees' health care providers and to Cigna itself as the plan administrator.

> Employer shall establish as a part of its general assets a Bank Account, and maintain in the Bank Account an amount sufficient at all times to fund payments from it for the following (collectively "**Bank Account Payments**"): (i) Plan Benefits; (ii) those charges and fees identified in the Schedule of Financial Charges as payable through the Bank Account and (iii) any sales or use taxes, or any similar benefit- or Plan-related charge or assessment however denominated, which may be imposed by any governmental authority. Bank Account Payments may include without limitation: (a) fixed per person payments and pay-for-performance payments to Participating Providers; (b) amounts owed to CHLIC; and (c) amounts paid to CHLIC's affiliates and/or subcontractors for, among other things, network access or in- and out-of network health care services/products provided to Members. CHLIC may credit the Bank Account with payments due Employer under a stop loss policy issued by CHLIC or an affiliate.

E.g., Ex. C at 6, § 3(a).

> CHLIC, as agent for the Employer, shall make Bank Account Payments from the Bank Account in the amount CHLIC reasonably determines to be proper under the Plan and/or under this Agreement.

E.g., Ex. G at 5, § 3(b).

24. Cigna also offers employers "Additional Services" related to their plans, as provided in Cigna's standard ASO agreements. *Id.* at 4, § 2.

> In addition to the basic claim administrative duties described above, CHLIC shall also perform the Plan-related administrative duties agreed upon by the Parties and specified in Exhibit B and [redacted] shall provide the services described in Addendum A.

Id. at 4, § 2(d). Under Cigna's ASO agreements, "Plan-related administrative duties" include "[d]iscuss[ing] claims, when appropriate, with providers of health services," and the "negotiation" of out-of-network providers' fees for services rendered. *E.g.*, Ex. E at 29, ¶4; *id.* at 22.

25. Out-of-network providers include ground ambulance companies, whose fees become liabilities not only of self-funded ERISA plans, but also of covered employees who end up needing ambulance care.

"Balance Billing" For Ground Ambulance Services In The United States

26. The ERISA plans Cigna administers under its ASO agreements cover many services provided by out-of-network healthcare professionals, which Cigna sometimes calls "non-Participating Providers." *Id.* at 3 (defining "Participating Providers" as providers who have affirmatively contracted with Cigna to care for plan participants); *see also id.* at 22 (referencing "covered services received from a non-Participating Provider").

27. Historically, when an out-of-network provider such as a doctor, hospital, or ambulance company cared for a covered patient, the responsible insurance company (whether acting as a TPA or insurer) would pay the provider less than their full fee for services. The healthcare provider would then bill the patient directly, for whatever amount of their full fee the insurance company did not to pay. This practice became known as "balance billing," as providers billed patients directly for the remaining "balance" of their fees that went unpaid by the responsible insurer or ERISA plan.

28. Cigna's ERISA plan booklets, which explain the benefits and limitations of coverage for plan participants, define "surprise billing" as "an unexpected balance bill." *See, e.g.,* Ex. A at 11-12 (Plaintiff's ERISA plan booklet, created by Cigna). Cigna's booklets explain that surprise billing "can happen when you cannot control

who is involved in your care—such as when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider." *Id.* at 12. Cigna further explains that surprise medical bills may cost patients "thousands of dollars depending on the procedure or service." *Id.*

29. In recent years, Congress prohibited surprise billing by most out-of-network healthcare providers, through the federal "No Surprises Act." 29 U.S.C § 1185e(b). The No Surprises Act required out-of-network healthcare providers to negotiate their fees for services directly with ERISA plans and administrators, instead of balance billing patients directly. Additionally, the Act required ERISA plans to charge covered patients only their *in*-network "cost-sharing requirement[s]" for various out-of-network services. *Id*; 29 U.S.C § 1185e(c). Congress thus rendered covered employee-patients largely unaffected by the differences between what their ERISA plans wish to pay, and what their healthcare providers wish to earn, as compensation for their care.

30. Through the No Surprises Act, Congress even enacted a specific prohibition against surprise balance-billing by ambulance companies. 29 U.S.C. § 1185f. That specific prohibition, however, was limited to "*air* ambulance services." *Id.*[2] (emphasis added). Congress intentionally left *ground* ambulance providers federally unregulated in their balance-billing of patients covered by ERISA plans. *Id.* Largely because of this statutory loophole, ground ambulance providers still surprise-bill covered patients for the full, remaining balances of any unnegotiated ambulance charges that patients' health plans decline to pay.

31. For example, if a plan pays a ground ambulance provider $3,000 on behalf of a covered employee, in response to a $3,500 fee submitted by the ambulance provider, the provider directly bills the employee for the remaining $500. If the plan

[2] All emphasis within cited quotations is added unless otherwise indicated herein.

instead pays the ambulance provider only $2,000, then the ambulance provider bills and pursues the covered patient for the remaining $1,500.

Cigna's Contractual Conflict Of Interest With ERISA Plan Participants

32. As detailed in ¶¶21-25, *supra*, Cigna manages the operations and finances of health plans funded by large, corporate employers in the United States. Under its ASO agreements with employers, Cigna's managerial work includes "negotiat[ing]" and paying (on behalf of employer-funded plans) out-of-network providers' charges for services rendered to covered employees. *See* Ex. C at 20; Ex. D at 19; Ex. E at 22; Ex. F. at 25; Ex. G at 14. This includes ground ambulance providers' charges. *E.g.,* Ex. A at 34 (referencing "charges for licensed Ambulance service to the nearest Hospital where the needed medical care and treatment can be provided" as a "Covered Expense").

33. Under Cigna's ASO agreements with employers, Cigna has contracted to earn up to 29% of all ground ambulance charges that go *unpaid* by employers' ERISA plans. *See* Ex. C at 20-21; Ex. D at 19-20; Ex. E at 22-23; Ex. F. at 25-26; Ex. G at 14-15. As the plan administrator vested with discretionary authority over claims on plan assets, Cigna effectively controls how much money its administered plans pay for every ground ambulance claim received. Indeed, Cigna decides the precise dollar amounts that administered plans pay to ground ambulance providers, for every covered instance of ambulance care that gets invoiced. The full invoice of ambulance charges comes in to Cigna from the ambulance provider, and Cigna decides how much of that bill to pay on behalf of the responsible health plan. As a result, Cigna effectively decides how much money it makes *for itself* on every ground ambulance claim it processes; the less a health plan pays, the more Cigna earns as a contingency fee from the plan-funding employer: up to 29% of the unpaid balance of ambulance charges. Meanwhile, Cigna knows that ground ambulance providers pursue covered employees for 100% of such unpaid balances.

34. Thus, Cigna knows that whatever amount it decides to earn for itself as a contingency fee, covered employee-patients will be billed *more than three times that amount* by their ambulance providers, as a surprise "balance bill." This creates a clear and undisclosed, financial conflict of interest between Cigna as a plan administrator, and covered employee-participants in the ERISA plans Cigna administers under its ASO agreements: particularly those participants who require ambulance care.

35. ERISA requires Cigna to "discharge [its] duties with respect to a plan *solely* in the interest of the participants and beneficiaries" of the plan. 29 U.S.C. § 1104(a)(1). The 29% contingency fees written into Cigna's ASO agreements with employers fail to satisfy this standard in the context of ground ambulance care. By charging employers contingent, percentage-based fees for minimizing plan payments to ground ambulance providers, Cigna has contractually undertaken to "negotiate" such payments in its own interests, and to the detriments of plan participants, rather than "solely" in participants' interests. *Id.*

36. There is no special need for Cigna to charge employers percentage-based contingency fees, rather than flat fees or hourly rates, for "negotiating" lower plan payments to ground ambulance providers. If Cigna charged employers flat fees or hourly rates for "negotiating" ground ambulance bills, then Cigna could perhaps remain disinterested in the ultimate outcomes of those negotiations. Employers could still save some money, and covered employees might still owe some money for whatever ambulance services they received, but Cigna *itself* would not profit based on how it allocates an ambulance provider's charges between a covered employee and their employer.

37. By charging employers percentage-based, "cost containment fees" for minimizing plan payments to ground ambulance providers, Cigna has unnecessarily and unlawfully placed *its own* skin in the game of pricing ground ambulance coverage for corporate employers throughout the United States. Moreover, Cigna has rigged

that game for its own benefit, by unreasonably underpaying ground ambulance providers to the detriments of covered employees.

38. In Plaintiff's case, Cigna decided that his ERISA plan would pay his ground ambulance provider, American Medical Response, Inc. ("AMR"), just $386.77 of AMR's $3,644.91 fee for ambulance services rendered to Plaintiff. AMR's total ambulance fees were specifically limited by law, yet Cigna had Plaintiff's ERISA plan pay just ~10% of AMR's regulated fees, while knowing that AMR would surprise-bill Plaintiff for the remaining ~90% of its fees, totaling $3,258.14.

39. Cigna then reported to Plaintiff's employer that it had reduced AMR's fees by $3,258.14, through "negotiation." Based on that representation to Plaintiff's employer, Cigna charged his employer 29% of its purported, $3,258.14 cost reduction, under its ASO agreement with his employer. Cigna thus decided and ensured that it would earn nearly $1,000 from Plaintiff's employer—for simply processing his ambulance bill—while AMR would earn only $386.77 from Plaintiff's employer for providing paramedic and ambulance services to Plaintiff on demand. Nearly $1,000 for Cigna's computers to push a few digital papers: yet less than $400 for AMR to bring a specialized vehicle and multiple medical professionals into Plaintiff's immediate service.

40. Such a facially extreme, economic imbalance results from Cigna's conflicted, "cost-containment fees" baked into its ASO agreements with corporate employers. *E.g.,* Ex. C at 20-21; Ex. D at 19-20; Ex. E at 22-23; Ex. F. at 25-26; Ex. G at 14-15. Because of Cigna's conflicts of interest with covered employees, Cigna unreasonably and self-interestedly suppresses ERISA plans' payments for ground ambulance services, and knowingly leaves covered employees like Plaintiff holding the bag. This contravenes ERISA's mandate that plan administrators act reasonably, and act "solely" in the interests of plan participants and beneficiaries. 29 U.S.C. § 1104(a)(1).

Cigna's Concealment Of Its Conflicted Compensation

41. Cigna declines to adequately disclose its conflict of interest with plan participants and beneficiaries in its processing of ground ambulance claims. If anything, Cigna's affirmative disclosures to employers and covered patients misleadingly suggest that no conflict exists.

42. *First*, to covered employee-patients, Cigna nowhere discloses that it earns higher contingency fees from having their employers pay smaller portions of their ground ambulance bills. When a covered employee needs an ambulance, and their ambulance provider submits its claim for payment, Cigna sends the employee a standard "Explanation of Benefits" ("EOB") document, detailing whether and how much of their ambulance costs were covered by their health plan. *E.g.,* Ex. B. Cigna's standard EOB documents routinely misrepresent to employee-patients that their ambulance costs have been "100%" paid by their plans: when in fact, at Cigna's direction, their plans paid only a small, minority percentage of their ambulance costs. *Id.* Cigna's EOBs further misrepresent to covered patients that they owe "$0.00" for their ambulance care, when in fact, Cigna knows they will be billed directly by their ambulance providers for thousands of dollars each. *Id.*

43. *Second*, with respect to employers, Cigna's ASO agreements say that Cigna administers "programs to contain costs for health care services/supplies that are covered by the Plan." *See, e.g.,* Ex. C at 20-21; Ex. D at 19-20; Ex. E at 22-23; Ex. F. at 25-26; Ex. G at 14-15. The ASO agreements state that: "[f]or charges for covered services received from a non-Participating Provider (including emergency/urgent care services that are covered at the in-network benefit level), [Cigna] may apply discounts under agreements with third parties *or through negotiation of the billed charges*." *Id.* The ASO agreements assert that "applying these discounts *avoids balance billing and substantially reduces the patient's out-of-pocket costs.*" *Id.*

44. The specific "programs" and "discounts" Cigna references here (*id.*) include its "Physician/Professional Bill Review" (or "Bill Review") program. *Id.* The Bill Review program consists of both "Professional Fee Negotiation" and "Line Item Analysis Re-pricing" discounts. *Id.* Contractually, Cigna earns from plan-funding employers up to 29% of any purported, "net savings" resulting from Cigna's provider "Negotiation[s]" and "Re-pricing." *Id.*

45. Nowhere, however, does Cigna adequately disclose to employers that the "discounts" it negotiates or calculates fail to reduce employees' "out-of-pocket costs" when they require ambulance care. *But see id.* (Cigna representing that "applying these discounts avoids balance billing and substantially reduces the patient's out-of-pocket costs"). In truth, Cigna's purported "discounts" *increase* patients' "out-of-pocket costs" dollar-for-dollar with respect to ground ambulance care, as such "discounts" themselves become the balance bills patients receive directly from their ambulance providers. Cigna knows that its purported, ground ambulance "discounts" become "out-of-pocket cost" *increases* for covered ambulance patients, yet still charges patients' employers 29% of those undisclosed cost increases, as "cost containment fees" under Cigna's ASO agreements.

46. Cigna's misstatements and concealments of the true facts surrounding its conflicted compensation allow it to continue charging large, corporate employers up to $1,000 or more per ambulance claim, from among millions of U.S. employees. Cigna has misleadingly profited from administering ERISA health plans in a self-interested manner, and against covered patients' interests, with respect to ground ambulance claims.

Plaintiff's Experience With Cigna's Unlawful Conduct

46. Plaintiff Daniel Kreutzmann is a San Diego County resident who went to a local hospital, Sharp Memorial, seeking treatment for insomnia on or about May 1,

2025. The hospital's medical staff evaluated Plaintiff's condition and determined that he would be better treated at a different facility, a half mile down the road.

47. The hospital's staff told Plaintiff that he would need to be transported there by ambulance, per hospital policy. Given the short distance and Plaintiff's non-emergency status, Plaintiff questioned the hospital's policy, but ultimately consented to ambulance transport once the hospital's staff reaffirmed its stated policy.

48. An AMR ambulance soon arrived to transport Plaintiff, per the hospital's instructions. Hospital staff walked him out to the ambulance, where AMR paramedics checked his vitals, asked him some questions, and proceeded to drive him down the road for about two minutes, to the nearby facility where he was ultimately treated.

49. At the time of Plaintiff's ambulance ride, he had ERISA health coverage from his employer, a multibillion-dollar company operating nationally and internationally. Like many large, corporate employers, Plaintiff's employer self-funds its employees' healthcare under an ERISA plan designed and administered by Cigna. Plaintiff pays for his health plan through his continuing service to his employer and through regular, cash deductions from his paycheck. Under an ASO agreement between Cigna and Plaintiff's employer—the terms of which are dictated primarily by Cigna—Cigna serves as the third-party administrator of Plaintiff's health plan.

50. Two weeks after Plaintiff's May 1, 2025 ambulance ride, AMR sent Cigna its invoice for paramedic and ambulance services, totaling $3,644.91. Cigna promptly processed AMR's claim and, upon doing so, sent Plaintiff a standard Explanation of Benefits document, representing that Cigna had "negotiate[d]" AMR's ambulance charges from $3,644.91, down to $386.77. *Id.* at 1. The EOB further stated that Plaintiff's plan had paid AMR $386.77, such that Plaintiff owed "$0.00" and "saved $3,644.91 (100%) off the total amount billed." *Id.* All such representations were materially false and misleading when made to Plaintiff by Cigna.

51. Yet Plaintiff had no reason to disbelieve Cigna's EOB at the time, so he reasonably believed his ambulance costs had been "100%" negotiated and paid by his health plan, as stated in Cigna's EOB. *Id.* It was not until several months later that Plaintiff would first learn otherwise.

52. In or about November 2025, Plaintiff received a $3,258.14 bill from AMR: much more than the "$0.00" Cigna's EOB said he owed, and much more than the "$386.77" Cigna said it "negotiate[d]" with AMR. *Compare* Ex. B at 1, *with* Ex. H. At first, Plaintiff thought AMR's bill might be fake, so he called AMR by phone to verify the bill's authenticity. AMR's phone representative confirmed it.

53. AMR's representative told Plaintiff that the total cost of his ambulance care was $3,644.91, that his "insurance" had paid for $386.77 of it, and that Plaintiff owed the remaining $3,258.14. *Accord* Ex. H at 3. AMR affirmed its $3,258.14 bill to Plaintiff as legitimately owed.

54. Plaintiff expressed to AMR's phone representative his difficulty in paying such a large amount—an amount that Cigna said he had "saved." Ex. B at 1. In response, AMR offered to put Plaintiff on a monthly payment plan to avoid default. Plaintiff reluctantly agreed to AMR's proposed payment plan and began making monthly payments to AMR, fearing damage to his personal credit if he failed to pay. Plaintiff continues to pay AMR's monthly bills to this day. *E.g.,* Ex. H at 3-4.

55. Plaintiff subsequently contacted Cigna while continuing to make monthly payments to AMR. Cigna's phone representative said that, if AMR was dissatisfied with the amount Plaintiff's health plan paid, then AMR should "negotiate" its bill directly with Cigna, before billing Plaintiff for the unpaid, $3,258.14 balance. Cigna's EOB, however, had represented to Plaintiff months prior that such "negotiat[ions]" already occurred. Ex. B at 1.

56. There was no indication from Cigna's representative what contractual or other legal obligations AMR might owe to Cigna, or vice versa. Ultimately, Cigna afforded Plaintiff no help in paying or even communicating with AMR.

57. Consequently, Plaintiff is now paying AMR $3,258.14 for his two-minute, non-emergency ambulance ride, which was (purportedly) "100%" negotiated and paid for by his Cigna-administered health plan.

Cigna's Unlawful Conflicts of Interest Cause Substantial Harm To The Class

58. Cigna earned nearly $1,000 as a contingency fee, just for slashing by over $3,000 what Plaintiff's health plan paid for his ambulance care. Yet Cigna never disclosed its contingent earnings to Plaintiff as an ERISA plan participant, to whom Cigna owes fiduciary duties of reasonable care and exclusive loyalty. 29 U.S.C. § 1104(a)(1).

59. At least thousands of other participants in self-funded ERISA plans administered by Cigna have incurred and paid multi-thousand dollar ambulance bills, which received about 10% coverage at Cigna's direction, so that Cigna could profit off the remaining 90% through its undisclosed contingency fees. Cigna has done this on misleading pretenses, and in violation of ERISA's requirement that Cigna administer employee health plans "solely" in the interests of plan participants and beneficiaries. *Id.*

60. Plaintiff and the Class have been harmed not only by their excessive bills for ambulance care, but also by overpaying for private health coverage that Cigna was secretly administering against their interests for its own, undisclosed financial gains.

CLASS ACTION ALLEGATIONS

61. Plaintiff brings this action as a class action pursuant to Federal Rules of Civil Procedure 23(a), (b)(2) and (b)(3), on behalf of himself and all other persons within the United States (the "Class") who have been balance billed for out-of-network ground ambulance services provided to them while they were participants in,

or beneficiaries of, an employer-sponsored health plan administered by Cigna, under an Administrative Services Only agreement between Cigna and the employer. Excluded from the Class are Cigna's and its affiliates' officers and directors, members of their immediate families, and their legal representatives, heirs, successors, and assigns.

62. Members of the Class are so numerous that the joinder of all members is impracticable. While the exact number of Class members is unknown to Plaintiff at this time, and can be ascertained only through appropriate discovery, Plaintiff believes there are at least thousands of members of the proposed Class. Class members may be efficiently identified and located from database records maintained by Cigna, and notified of the pendency of this action by electronic mail and/or regular mail using the forms of notice similar to those customarily used in class actions such as this.

63. Plaintiff's claims are typical of other Class members' claims, as all Class members are similarly affected by Cigna's wrongful conduct as complained of herein.

64. Plaintiff will fairly and adequately protect the interests of Class members, and has retained counsel competent and experienced in class action litigation. Plaintiff and his counsel have no interests antagonistic to, or in conflict with, those of the Class.

65. Cigna has demonstrably acted on grounds generally applicable to the Class, such that final injunctive and declaratory relief are appropriate respecting the Class as a whole.

66. Common questions of law and fact exist as to all Class members, and such questions predominate over questions affecting only individual members of the Class. Questions of law and fact that are common and predominate among Plaintiff and other Class members include, without limitation:

a. whether the contingent, "cost containment" fees provided in Cigna's ASO agreements with employers violated Cigna's statutory duties to Class members;

b. whether Cigna used its role and discretion as an administrator of ERISA plans to systematically minimize plan payments to ground ambulance providers;

c. whether, when, and how Cigna knew that participants in the ERISA plans it administers would be balance billed by ground ambulance companies;

d. whether Cigna made materially false and misleading statements to ERISA plan participants and/or their employers, concerning whether plan participants would be balance-billed by ground ambulance providers;

e. whether Cigna concealed from ERISA plan sponsors and participants that it was earning more money for itself, by increasing covered patients' financial exposures to ground ambulance charges, after the fact of care;

f. whether the totality of Cigna's conduct in administering claims for ground ambulance services violated ERISA's mandate that named fiduciaries act "solely" in the interests of plan participants; and

g. whether Plaintiff and the Class have suffered economic harm from Cigna's conduct, and the appropriate remedies, if any, for such harm.

67. A class action is superior to all other available methods for the fair and efficient adjudication of this controversy, as the joinder of all members is impracticable. Furthermore, because the harm suffered by individual Class members is relatively small, the expense and burden of individual litigation would make it difficult if not impossible for members of the Class to redress the wrongs done to them on an individual basis. There will be no substantial difficulty in the management of this case as a class action.

FIRST RIGHT OF ACTION

Violations of ERISA, 29 U.S.C. § 1104 – Breaches of Fiduciary Duties

68. Plaintiff hereby incorporates by reference all allegations contained in all other paragraphs of this Complaint, as if fully set forth herein.

69. ERISA imposes upon third-party administrators of employee health plans

fiduciary duties of exclusive loyalty and reasonable care with respect to plan participants and their beneficiaries. Specifically, ERISA provides that "a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

> (A) for the exclusive purpose of:
>
> (i) providing benefits to participants and their beneficiaries; and
>
> (ii) defraying reasonable expenses of administering the plan; [and]
>
> (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims."

29 U.S.C. § 1104(a)(1).

70. At all relevant times, Cigna has violated § 1104(a)(1) and, independently, violated each of § 1104(a)(1)'s subsections (A) and (B), in its administration of Plaintiff's and the Class's ground ambulance claims.

71. *First*, Cigna's unnecessary, percentage-based contingency fees in its ASO agreements with Plaintiff's and the Class's employers vested in Cigna a direct and personal, financial interest in the discharge of its duties as an ERISA plan administrator. Such fees rewarded Cigna for using its claim-"negotiating" and "repricing" discretion as an administrator to *minimize* plan payments to out-of-network providers, including but not limited to ground ambulance providers throughout the United States. Cigna's undisclosed, self-created contingency fees, coupled with its systematic use of its administrative discretion to maximize its own contingency fees to the detriments of covered employees, constitute Cigna's failure to "discharge [its] duties with respect to a plan *solely* in the interest of the participants and beneficiaries" of the plan. 29 U.S.C. § 1104(a)(1) (emphasis added).

72. In the same vein, Cigna has "discharge[d] [its] duties" as an administrator for a "purpose" other than "providing benefits to participants and their beneficiaries"

and "defraying reasonable expenses of administering the plan": specifically, for the impermissible "purpose" of maximizing its own contingent, percentage-based fees via its "negotiation" and "repricing" of ground ambulance providers' fees. 29 U.S.C. § 1104(a)(1)(A).

73. *Second*, at all relevant times, Cigna has known that "the circumstances then prevailing" in the United States healthcare industry have included, without limitation, the balance billing of ERISA plan participants by ground ambulance providers. 29 U.S.C. § 1104(a)(1)(B). Cigna's systematic practice of charging plan sponsors (*i.e.,* employers) 29% contingency fees, and using its administrative discretion to minimize plan payments to providers, constitutes an absence of the requisite "care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use," in the administration of corporate employers' self-funded ERISA health plans. *Id.*

74. Cigna's contingency fees create unnecessary, financial conflicts of interest between Cigna on the one hand, and ERISA plan participants and beneficiaries on the other hand, particularly in contexts where out-of-network providers—such as ground ambulance providers—directly pursue plan participants and beneficiaries for the balances of their fees that go unpaid by participants' health plans.

75. Cigna could easily have contracted with ERISA plan sponsors (*i.e.,* large, corporate employers) to charge flat rates, hourly rates, or any other *disinterested* rate structure for its administrative service in "negotiating" and "repricing" ground ambulance providers' fees for services rendered. Instead, Cigna specifically chose to contract and earn for itself contingency fees, calculated as a percentage of covered employee-patients' exposures to ground ambulance charges, and then, calculated such fees and exposures self-interestedly using its own administrative discretion.

76. At minimum, the totality Cigna's conduct was and is impermissibly self-serving, and independently, lacking in the care, skill, prudence, and diligence required

of a health plan administrator for millions of U.S. employees earning and buying private health coverage from their employers.

77. Due to Cigna's systematic breaches of its fiduciary duties, Plaintiff and the Class have suffered multiple forms of economic harm. Such harms include, without limitation: (a) participating in and overpaying for ERISA health plans administered by an insurance company that has undisclosed, contractual conflicts of interests with Plaintiff's and the Class's interests as plan participants and beneficiaries; and (b) being billed for, paying, and/or facing collections with respect to, thousands of dollars each in ground ambulance charges, which were purportedly "100%" covered by their Cigna-administered health plans.

SECOND RIGHT OF ACTION
Violations of ERISA, 29 U.S.C. § 1106 – Prohibited Transactions

78. Plaintiff hereby incorporates by reference all allegations contained in all other paragraphs of this complaint, as if fully set forth herein.

79. ERISA provides that a "fiduciary with respect to a plan shall not . . . deal with the assets of the plan in his own interest or for his own account." 29 U.S.C. § 1106(b)(1).

80. Cigna, in exercising its delegated, administrative discretion to act on behalf of and/or in the interests of ERISA plan sponsors, participants and beneficiaries, has dealt with ERISA plan assets in its own interests by "negotiating," "repricing," and otherwise controlling the expenditure of plans' monetary assets to minimize plan payments to ground ambulance providers for covered services—so as to maximize Cigna's direct receipts of plan assets from plan bank accounts, in the form of contingent, "cost containment fees" transferred by Cigna from plan bank accounts into Cigna's own bank account(s).

81. As a result of Cigna's prohibited transactions executed for its own, inadequately disclosed financial gain, Plaintiff and the Class have suffered multiple

forms of economic harm. Such harms include, without limitation: (a) participating in and overpaying for ERISA health plans administered by a TPA engaged in undisclosed self-dealing, using their health plans' monetary assets; and (b) being billed for, paying, and/or facing collections with respect to, thousands of dollars in ground ambulance charges (per Class member), which were purportedly "100%" covered by their Cigna-administered health plans. *E.g.,* Ex. B at 1.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff, on behalf of himself and the Class, hereby demands judgment against Cigna as follows:

A. Determining that the instant action may be maintained as a class action under Rule 23 of the Federal Rules of Civil Procedure, and certifying Plaintiff as a Class Representative, and the law firm of Harris LLP as Class Counsel;

B. For an award of equitable surcharges in the amounts of Plaintiff's and the Class's balance bills incurred for ground ambulance services they received;

C. For an award equitably disgorging to Plaintiff and the Class all of Cigna's undisclosed, "cost containment fees" earned from processing their ground ambulance claims;

D. For an order permanently and publicly enjoining Cigna from charging, or collecting from, any self-funded ERISA plan sponsor any fee that is contingent upon a purported reduction to a ground ambulance provider's fees for covered ambulance services rendered to ERISA plan participants or beneficiaries;

E. Awarding Plaintiff and the Class prejudgment and post-judgment interest, as well as reasonable attorneys' fees, expert fees, and all other costs and expenses of this action; and

F. Awarding any other relief that this Court deems just and proper.

JURY DEMAND

Plaintiff hereby demands a trial by jury.

Dated: October 12, 2026

Respectfully submitted,

HARRIS LLP

By: *s/ David J. Harris, Jr.*

David J. Harris, Jr.
Gerilyn R. Harris
501 West Broadway, Suite 800
San Diego, California 92101
Telephone: (619) 213-1102
david@harrisllp.com
gerilyn@harrisllp.com

Counsel for Plaintiff and the Putative Class

JS 44 (Rev. 03/24)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM)*

I. (a) PLAINTIFFS

Daniel Kreutzmann

(b) County of Residence of First Listed Plaintiff San Diego
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*

Harris LLP; 501 West Broadway, Suite 800, San Diego, California 92101; (619) 213-1102

DEFENDANTS

Cigna Health and Life Insurance Company

County of Residence of First Listed Defendant
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

'26CV5836 CAB BJW

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☒ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☒ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
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- ☐ 530 General
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Other:
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FORFEITURE/PENALTY
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- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
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- ☒ 791 Employee Retirement Income Security Act

IMMIGRATION
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- ☐ 465 Other Immigration Actions

BANKRUPTCY
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- ☐ 423 Withdrawal 28 USC 157

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- ☐ 840 Trademark
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SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

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- ☐ 871 IRS—Third Party 26 USC 7609

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- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit (15 USC 1681 or 1692)
- ☐ 485 Telephone Consumer Protection Act
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
29 U.S.C. sections 1104, 1106, 1132(a)(3)

Brief description of cause:
Violations of fiduciary duties and prohibited transactions in connection with Defendant's administration of ERISA health plans

VII. REQUESTED IN COMPLAINT:

☒ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

DEMAND $ equitable relief

CHECK YES only if demanded in complaint:
JURY DEMAND: ☒ Yes ☐ No

VIII. RELATED CASE(S) IF ANY *(See instructions):*

JUDGE _____ DOCKET NUMBER _____

DATE: October 12, 2026

SIGNATURE OF ATTORNEY OF RECORD: s/ David J. Harris, Jr.

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

EXHIBIT A

[redacted]

OPEN ACCESS PLUS IN-NETWORK
MEDICAL BENEFITS

EFFECTIVE DATE: August 1, 2025

ASO48
3331771

This document printed in August, 2025 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

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Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY [redacted] WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CIGNA HEALTH AND LIFE INSURANCE COMPANY (CIGNA) PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CIGNA DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CIGNA. BECAUSE THE PLAN IS NOT INSURED BY CIGNA, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CIGNA," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

HC-NOT89

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

Special Plan Provisions

Participating Providers include Physicians, Hospitals and Other Health Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

Services Available in Conjunction With Your Medical Plan

The following pages describe helpful services available in conjunction with your medical plan. You can access these services by calling the toll-free number shown on the back of your ID card.

HC-SPP70 01-21

Case Management

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

- You, your dependent or an attending Physician can request Case Management services by calling the **toll-free number** shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.
- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.
- Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

HC-SPP2 04-10
V1

Additional Programs

We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to our members for the purpose of promoting the general health and well being of our members. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Policyholder. Contact us for details regarding any such arrangements.

HC-SPP3 04-10
V1

Incentives to Participating Providers

Cigna continuously develops programs to help our customers access quality, cost-effective health care. Some programs include Participating Providers receiving financial incentives from Cigna for providing care to members in a way that meets or exceeds certain quality and/or cost-efficiency standards, when, in the Participating Provider's professional judgment, it is appropriate to do so within the applicable standard of care. For example, some Participating Providers could receive financial incentives for prescribing lower-cost prescription drugs to manage certain conditions, utilizing or referring you to alternative sites of care as determined by your plan rather than in a more expensive setting, or achieving particular outcomes for certain health conditions. Participating Providers may also receive purchasing discounts when purchasing certain prescription drugs from Cigna affiliates. Such programs can help make you healthier, decrease your health care costs, or both. These programs are not intended to affect your access to the health care that you need. We encourage you to talk to your Participating Provider if you have questions about whether they receive financial incentives from Cigna and whether those incentives apply to your care.

HC-SPP85 01-24

Care Management and Care Coordination Services

Your plan may enter into specific collaborative arrangements with health care professionals committed to improving quality care, patient satisfaction and affordability. Through these collaborative arrangements, health care professionals commit to proactively providing participants with certain care management and care coordination services to facilitate achievement of these goals. Reimbursement is provided at 100% for these services when rendered by designated health care professionals in these collaborative arrangements.

HC-SPP27 06-15
V1

Important Information Regarding Tiering

This plan includes tiered benefits for certain covered services identified in The Schedule rendered by Participating Providers. Under tiered benefits, you pay a lower Copayment or Coinsurance level for certain covered services rendered by Tier 1-identified Participating Providers than if you receive the same covered services from a Participating Provider that is not identified by Cigna as a Tier 1 Participating Provider.

Cigna identifies Participating Providers as "Tier 1" based on consideration of criteria used to measure cost-efficiency and quality and consideration of other factors, including, but not limited to, local market need.

Refer to The Schedule to identify the covered services that are subject to tiered benefits. In order to receive a higher level of In-Network benefits for covered services identified in The Schedule as subject to a tiered benefit, you should also verify that your Primary Care Physician, or Specialist as applicable, has been designated by Cigna as a Tier 1 Participating Provider. Participating Provider tier designations are assessed and may change annually. You can access a list of all Participating Providers by visiting www.cigna.com or mycigna.com; or by calling the toll-free telephone number on your ID card. Tier 1 Participating Providers are specifically identified in this listing.

HC-SPP71 01-21

Important Notices

Important Information

Rebates and Other Payments

Cigna or its affiliates may receive rebates or other remuneration from pharmaceutical manufacturers in connection with certain Medical Pharmaceuticals covered under your plan. These rebates or remuneration are not obtained on you or your Employer's or plan's behalf or for your benefit.

Cigna, its affiliates and the plan are not obligated to pass these rebates on to you, or apply them to your plan's Deductible if any or take them into account in determining your Copayments and/or Coinsurance. Cigna and its affiliates or designees, conduct business with various pharmaceutical manufacturers separate and apart from this plan's Medical Pharmaceutical benefits. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this plan. Cigna and its affiliates are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, Cigna or its designee may send mailings to you or your Dependents or to your Physician that communicate a variety of messages, including information about Medical Pharmaceuticals. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you or your Dependents, at your discretion, to purchase the described Medical Pharmaceutical at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Cigna, its affiliates and the plan are not responsible in any way for any decision you make in connection with any coupon, incentive, or other offer you may receive from a pharmaceutical manufacturer or Physician.

HC-IMP385 01-25

Discrimination is Against the Law

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free phone number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HC-NOT96 07-17

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY : اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese –
注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711را شماره‌گیری کنید).

HC-NOT97 07-17

Federal CAA - Consolidated Appropriations Act and TIC - Transparency in Coverage Notice

Cigna will make available an internet-based self-service tool for use by individual customers, as well as certain data in machine-readable file format on a public website, as required under the Transparency in Coverage rule. Customers 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, Cigna 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, Cigna will submit certain prescription drug and health care spending information to HHS through Plan Lists Files (P1-P3) and Data Files (D1-D8) (D1-D2) for an

Employer without an integrated pharmacy product aggregated at the market segment and state level, as outlined in guidance.

HC-IMP353 01-24

Federal CAA - Consolidated Appropriations Act

Continuity of Care

In certain circumstances, if you are receiving continued care from an in-network provider or facility, and that provider's network status changes from in-network to out-of-network, you may be eligible to continue to receive care from the provider at the in-network cost-sharing amount for up to 90 days from the date you are notified of your provider's termination. A continuing care patient is an individual who is:

- undergoing a course of treatment for a serious and complex condition from the provider or facility.
- pregnant and undergoing treatment for the pregnancy from the provider or facility.
- undergoing a course of institutional or inpatient care from the provider or facility.
- scheduled to undergo non-elective surgery, including receipt of post-operative care with respect to such a surgery.
- determined to be terminally ill and is receiving treatment for such illness from the provider or facility.

If applicable, Cigna will notify you of your continuity of care options.

Appeals

Any external review process available under the plan will apply to any adverse determination regarding claims subject to the No Surprises Act.

Provider Directories and Provider Networks

A list of network providers is available to you, without charge, by visiting the website or calling the phone number on your ID card. The network consists of providers, including Hospitals, of varied specialties as well as generic practice, affiliated or contracted with Cigna or an organization contracting on its behalf.

Provider directory content is verified and updated, and processes are established for responding to provider network status inquiries, in accordance with applicable requirements of the No Surprises Act.

If you rely on a provider's in-network status in the provider directory or by contacting Cigna at the website or phone number on your ID card to receive covered services from that provider, and that network status is incorrect, then your plan cannot impose out-of-network cost shares to that covered service. In-network cost share must be applied as if the covered service were provided by an in-network provider.

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, access the website or call the phone number on your ID card.

Selection of a Primary Care Provider

This plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, access the website or call the phone number on your ID card.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network Hospital or ambulatory surgical center, you are protected from balance billing. In these situations, you should not be charged more than your plan's copayments, coinsurance, and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

"Out-of-network" means providers and facilities that have not signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**". This amount is likely more than in-network costs for the same

service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care – such as when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

- **Emergency services** – If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as a copayments, coinsurance, and deductibles). You cannot be balanced billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- **Certain non-emergency services at an in-network Hospital or ambulatory surgical center –** When you get services from an in-network Hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and may not ask you to give up your protections not to be balanced billed.

If you get other types of services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you have these protections:

- You are only responsible for paying your share of the cost (such as copayments, coinsurance, and deductibles that you would pay if the provider were in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval in advance for services (also known as prior authorization).
  - Cover emergency services provided by out-of-network providers.
  - Base what you owe the provider or facility (cost sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits (EOB).
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you have been wrongly billed, contact Cigna at the phone number on your ID card. You can also contact No Surprises Help Desk at 1-800-985-3059 or www.cms.gov/nosurprises for more information about your rights under federal law.

HC-IMP383 01-25

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) - Non-Quantitative Treatment Limitations (NQTLs)

Federal MHPAEA regulations provide that a plan cannot impose a Non-Quantitative Treatment Limitation (NQTL) on mental health or substance use disorder (MH/SUD) benefits in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, those used in applying the NQTL to medical/surgical benefits in the same classification of benefits as written and in operation under the terms of the plan.

A description of your plan's NQTL methodologies and processes applied to medical/surgical benefits and MH/SUD benefits is available by accessing the link at www.cigna.com/sp.

To determine which document applies to your plan, select the relevant health plan product; medical management model (inpatient only or inpatient and outpatient) which can be located in this booklet immediately following The Schedule; and pharmacy coverage (whether or not your plan includes pharmacy coverage).

HC-NOT137 01-24

How To File Your Claim

If your plan provides coverage when care is received only from In-Network providers, you may still have Out-of-Network claims (for example, when Emergency Services are received from an Out-of-Network provider) and should follow the claim submission instructions for those claims. Claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the website listed on your identification card or by using the toll-free number on your identification card.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.

  YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

  YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 180 days for Out-of-Network benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within 180 days for Out-of-Network benefits, the claim will not be considered valid and will be denied.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

HC-CLM25 01-11

V11

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees as determined by your Employer; and
- you are an eligible Employee as determined by your Employer; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Eligibility for Dependent Insurance

You will become eligible for Dependent Insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

A period of time as determined by your Employer.

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or

- you again elect it after you cancel your payroll deduction (if required).

Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 60 days after his birth. If you do not elect to insure your newborn child within such 60 days, coverage for that child will end on the 60th day. No benefits for expenses incurred beyond the 60th day will be payable.

HC-ELG274 M 01-19

Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

Opportunity to Select a Primary Care Physician

This medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by Cigna for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents. If you need assistance selecting your Primary Care Physician, please visit our website at www.cigna.com or call the number on the back of your ID Card.

The Primary Care Physician's role is to provide or arrange for medical care for you and any of your Dependents.

You and your Dependents are allowed direct access to Participating Physicians for covered services. Even if you select a Primary Care Physician, there is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the Participating Physician of your choice, including Participating Specialist Physicians, for covered services.

Changing Primary Care Physicians

You may request a transfer from one Primary Care Physician to another by visiting our website at www.cigna.com or calling the number on the back of your ID Card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician, if you choose.

Direct Access For Mental Health and Substance Use Disorder Services

You are allowed direct access to a licensed/certified Participating Provider for covered Mental Health and Substance Use Disorder Services. There is no requirement to obtain an authorization of care from your Primary Care Physician for individual or group therapy visits to the Participating Provider of your choice for Mental Health and Substance Use Disorder.

HC-IMP361 01-24

Open Access Plus In-Network Medical Benefits

The Schedule

For You and Your Dependents

Open Access Plus In-Network Medical Benefits provide coverage for care In-Network. To receive Open Access Plus In-Network Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

When you receive services from an In-Network Provider, remind your provider to utilize In-Network Providers for x-rays, lab tests and other services to ensure the cost may be considered at the In-Network level.

If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

Important Notice on Mental Health and Substance Use Disorder Coverage

Covered medical services received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to the Mental Health and Substance Use Disorder sections of The Schedule.

Coinsurance

The term Coinsurance means the percentage of Covered Expenses that an insured person is required to pay under the plan in addition to the Deductible, if any.

Copayments/Deductibles

Copayments are amounts to be paid by you or your Dependent for covered services. Deductibles are Covered Expenses to be paid by you or your Dependent before benefits are payable under this plan. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance.

Contract Year

Contract Year means a 12 month period beginning on 08/01/2025.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Deductibles, Copayments or Coinsurance. Such Covered Expenses accumulate to the Out-of-Pocket Maximum shown in The Schedule. When the Out-of-Pocket Maximum is reached, all Covered Expenses, except charges for non-compliance penalties, are payable by the benefit plan at 100%.

cigna healthcare

Open Access Plus In-Network Medical Benefits

The Schedule

Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon's allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon

The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

Out-of-Network Charges for Certain Services

Charges for services furnished by an Out-of-Network provider in an In-Network facility while you are receiving In-Network services at that In-Network facility: (i) are payable at the In-Network cost-sharing level; and (ii) the allowable amount used to determine the Plan's benefit payment is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or Federal law.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

Out-of-Network Emergency Services Charges

1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-Participating (Out-of-Network) provider.

2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or Federal law.

3. The allowable amount used to determine the Plan’s benefit payment when Out-of-Network Emergency Services result in an inpatient admission is the median amount negotiated with In-Network facilities.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

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Open Access Plus In-Network Medical Benefits

The Schedule

Out-of-Network Air Ambulance Services Charges

1. Covered air ambulance services are payable at the In-Network cost-sharing level if services are received from a non-Participating (Out-of-Network) provider.

2. The allowable amount used to determine the Plan's benefit payment for covered air ambulance services rendered by an Out-of-Network provider is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or Federal law.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

BENEFIT HIGHLIGHTS	IN-NETWORK
Lifetime Maximum	Unlimited
The Percentage of Covered Expenses the Plan Pays **Note:** "No charge" means an insured person is not required to pay Coinsurance.	100%
Out-of-Pocket Maximum	
Individual	$2,000 per person
Family Maximum	$6,000 per family
Family Maximum Calculation **Collective Out-of-Pocket Maximum:** All family members contribute towards the family Out-of-Pocket. An individual cannot have claims covered at 100% until the total family Out-of-Pocket has been satisfied.	
Primary Care Physician's Services	
Primary Care Physician's Office Visit	No charge after $20 per office visit copay
Surgery Performed in the Physician's Office	No charge after the $20 PCP per office visit copay
Second Opinion Consultations (provided on a voluntary basis)	No charge after the $20 PCP per office visit copay
Allergy Treatment/Injections	No charge
Allergy Serum (dispensed by the Physician in the office)	No charge

BENEFIT HIGHLIGHTS	IN-NETWORK
Specialty Care Physician Services **Note:** OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.	
Office Visits Consultant and Referral Physician's Services	No charge after the $30 Tier 1 or $40 non-Tier 1 Specialist per office visit copay
Surgery Performed by a Specialist in the Physician's Office	No charge after the $30 Tier 1 or $40 non-Tier 1 Specialist per office visit copay
Second Opinion Consultations performed by a Specialist (provided on a voluntary basis)	No charge after the $30 Tier 1 or $40 non-Tier 1 Specialist per office visit copay
Allergy Treatment/Injections performed by a Specialist	No charge
Allergy Serum (dispensed by the Specialist in the office)	No charge

BENEFIT HIGHLIGHTS	IN-NETWORK
Convenience Care Clinic (includes any related lab and x-ray services and surgery)	No charge after the $20 per office visit copay
Virtual Care **Dedicated Virtual Providers** Dedicated virtual care services may be provided by MDLIVE, a Cigna affiliate. Services available through contracted virtual providers as medically appropriate. **Notes:** • Primary Care cost share applies to routine care. Virtual wellness screenings are payable under preventive care. • MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below). • Lab services supporting a virtual visit must be obtained through dedicated labs.	
MDLIVE Urgent Care Services	No charge
MDLIVE Primary Care Services	No charge after the $20 per visit copay
MDLIVE Specialty Care Services	No charge
Virtual Physician Services Services available through Physicians as medically appropriate. **Note:** Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services).	
Physician Virtual Office Visit	No charge after the $20 PCP or applicable $30 Tier 1 or $40 non-Tier 1 Specialist per office visit copay

BENEFIT HIGHLIGHTS	IN-NETWORK
Preventive Care **Note:** Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit. **Other Services** Supplemental services, such as other common laboratory panel tests, when provided during a preventive visit. Routine Preventive Care - all ages Immunizations - all ages	 No charge No charge
Travel Immnuizations **Note:** Travel Immunizations are to be covered at non preventive level.	No charge
Mammograms, PSA, PAP Smear Preventive Care Related Services (i.e. “routine” services) Diagnostic Related Services (i.e. “non-routine” services)	 No charge Subject to the plan’s x-ray & lab benefit; based on place of service
Breast Cancer Screening – Expanded Coverage • Coverage of breast ultrasound and breast MRI as a follow-up to an inconclusive mammogram when there is no cancer or illness diagnosis. • Wellness screening are covered under Preventive Care services. • Services for the monitoring and treatment of cancer and illness are covered under the Radiology and Advanced Radiology Imaging benefits	No charge
Inpatient Hospital - Facility Services Semi-Private Room and Board Private Room Special Care Units (ICU/CCU)	$200 per admission copay, then 100% Limited to the semi-private negotiated rate Limited to the semi-private negotiated rate Limited to the negotiated rate

BENEFIT HIGHLIGHTS	IN-NETWORK
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	$100 per visit copay, then 100%
Note: Non-surgical treatment procedures are not subject to the facility copay/deductible.	
Inpatient Hospital Physician's Visits/Consultations	100% (PCP), 100% (Tier 1) or 100% (non-Tier 1)
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	 100% (Tier 1) or 100% (non-Tier 1) 100%
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	 100% (Tier 1) or 100% (non-Tier 1) 100%
Urgent Care Services Physician's Office Visit Urgent Care Facility or Outpatient Facility Outpatient Professional Services (radiology, pathology, physician) X-ray and/or Lab performed at the Urgent Care Facility (billed by the facility as part of the UC visit) Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	 No charge after the $20 PCP or applicable $30 Tier 1 or $40 non-Tier 1 Specialist per office visit copay No charge after $40 per visit copay* *waived if admitted No charge No charge No charge

BENEFIT HIGHLIGHTS	IN-NETWORK
Emergency Services	
Physician's Office Visit	No charge after the $20 PCP or applicable $30 Tier 1 or $40 non-Tier 1 Specialist per office visit copay
Hospital Emergency Room	No charge after $250 per visit copay* *waived if admitted
Outpatient Professional Services (radiology, pathology, ER physician)	No charge
X-ray and/or Lab performed at the Emergency Room Facility (billed by the facility as part of the ER visit)	No charge
Independent X-ray and/or Lab Facility in conjunction with an ER visit	No charge
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	No charge
Air Ambulance	100%
Ambulance	100%
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Contract Year Maximum: Unlimited	100%
Laboratory Services	
Laboratory Services in a Physician's Office Visit	No charge after the $20 PCP or applicable $30 Tier 1 or $40 non-Tier 1 Specialist per office visit copay
Laboratory Services in an Outpatient Hospital Facility	100%
Laboratory Services in an Independent Lab Facility	100%
Radiology Services	
Radiology Services in a Physician's Office Visit	No charge after the $20 PCP or applicable $30 Tier 1 or $40 non-Tier 1 Specialist per office visit copay
Radiology Services in an Outpatient Hospital Facility	100%

BENEFIT HIGHLIGHTS	IN-NETWORK
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)	
Physician's Office Visit	No charge
Inpatient Facility	$200 per admission copay, then 100%
Outpatient Facility	100%
Outpatient Therapy Services	
Contract Year Maximum: 60 days for all therapies combined (The limit is not applicable to mental health conditions.)	No charge after the $20 PCP or $40 non-Tier 1 Specialist per office visit copay
Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Note: There is no coverage review for Physical Therapy, Occupational Therapy.	**Note:** Outpatient Therapy Services copay applies, regardless of place of service, including the home.
Chiropractic Care	
Contract Year Maximum: 20 days	
Physician's Office Visit Note: There is no coverage review for Chiropractic Care	No charge after the $20 PCP or $40 non-Tier 1 Specialist per office visit copay
Acupuncture Self-referred, Medically Necessary treatment of pain or disease by acupuncture provided on an outpatient basis, limited to a 20 day maximum per person per Contract Year	
Physician's Office Visit	No charge after the $20 PCP or applicable $40 non-Tier 1 Specialist per office visit copay
Home Health Care Services	
Contract Year Maximum: Unlimited (includes up to 24 hours outpatient private nursing when approved as Medically Necessary)	100%

BENEFIT HIGHLIGHTS	IN-NETWORK
Hospice	
Inpatient Services	100%
Outpatient Services (same coinsurance level as Home Health Care Services)	100%
Bereavement Counseling	
Services Provided as part of Hospice Care	
Inpatient	100%
Outpatient	100%
Services Provided by Mental Health Professional	Covered under Mental Health benefit
Gene Therapy Includes prior authorized gene therapy products and services directly related to their administration, when Medically Necessary. Gene therapy must be received at an In-Network facility specifically contracted with Cigna to provide the specific gene therapy. Gene therapy at other In-Network facilities is not covered.	
Gene Therapy Product	Subject to In-Network facility cost share based on place of service; separate from facility charges
Inpatient Facility	$200 per admission copay, then 100%
Outpatient Facility	$100 per visit copay, then 100%
Physician's Services	100% (Tier 1) or 100% (non-Tier 1)
Travel Maximum: $10,000 per episode of gene therapy	No charge (available only for travel when prior authorized to receive gene therapy at a participating In-Network facility specifically contracted with Cigna to provide the specific gene therapy)

BENEFIT HIGHLIGHTS	IN-NETWORK
Advanced Cellular Therapy Includes prior authorized advanced cellular therapy products and related services when Medically Necessary.	
Advanced Cellular Therapy Product	100%
Inpatient Facility	$200 per admission copay, then 100%
Outpatient Facility	$100 per visit copay, then 100%
Physician's Services	100% (non-Tier 1)
Advanced Cellular Therapy Travel Maximum: $10,000 per episode of advanced cellular therapy (Available only for travel when prior authorized to receive advanced cellular therapy from a provider located more than 60 miles of your primary residence and is contracted with Cigna for the specific advanced cellular therapy product and related services.)	No charge
Maternity Care Services	
Initial Visit to Confirm Pregnancy **Note:** OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.	No charge after the $20 PCP or applicable $30 Tier 1 or $40 non-Tier 1 Specialist per office visit copay
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	100% (Tier 1) or 100% (non-Tier 1)
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	No charge
Delivery - Facility (Inpatient Hospital, Birthing Center)	$200 per admission copay, then 100%

BENEFIT HIGHLIGHTS	IN-NETWORK
Abortion	
Includes elective and non-elective procedures	
Physician's Office Visit	No charge after the $20 PCP or applicable $30 Tier 1 or $40 non-Tier 1 Specialist per office visit copay
Inpatient Facility	$200 per admission copay, then 100%
Outpatient Facility	$100 per visit copay, then 100%
Physician's Services	100% (Tier 1) or 100% (non-Tier 1)
Women's Family Planning Services	
Office Visits, Lab and Radiology Tests and Counseling	No charge
Note: Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician's office.	
Surgical Sterilization Procedures for Tubal Ligation	
Physician's Office Visit	No charge
Inpatient Facility	No charge
Outpatient Facility	No charge
Physician's Services	No charge
Men's Family Planning Services	
Office Visits, Lab and Radiology Tests and Counseling	No charge after the $20 PCP or applicable $30 Tier 1 or $40 non-Tier 1 Specialist per office visit copay
Surgical Sterilization Procedures for Vasectomy	
Physician's Office Visit	No charge after the $20 PCP or applicable $30 Tier 1 or $40 non-Tier 1 Specialist per office visit copay
Inpatient Facility	$200 per admission copay, then 100%
Outpatient Facility	$100 per visit copay, then 100%
Physician's Services	100% (Tier 1) or 100% (non-Tier 1)

BENEFIT HIGHLIGHTS	IN-NETWORK
Infertility Services Coverage is provided for the following services: • diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed (diagnosis of infertility is not required for treatment). • Access to reproductive services for the purposes of short term fertility preservation. **Treatment Per Lifetime Maximum:** $30,000* *Applies to egg freezing, in vitro fertilization, GIFT, ZIFT only. All other covered services do not accumulate to the Lifetime Maximum.	
Physician's Office Visit (Lab and Radiology Tests, Counseling)	No charge after the $20 PCP or applicable $30 Tier 1 or $40 non-Tier 1 Specialist per office visit copay
Inpatient Facility	$200 per admission copay, then 100%
Outpatient Facility	$100 per visit copay, then 100%
Physician's Services	100% (Tier 1) or 100% (non-Tier 1)
Transplant Services and Related Specialty Care Includes all medically appropriate, non-experimental transplants	
Physician's Office Visit	No charge after the $20 PCP or applicable $30 Tier 1 or $40 non-Tier 1 Specialist per office visit copay
Inpatient Facility	100% after $200 per admission copay at Cigna LifeSOURCE Transplant Network® facilities
Physician's Services	100% at Cigna LifeSOURCE Transplant Network® facilities
Lifetime Travel Maximum: $10,000 per transplant	No charge (only available when using Cigna LifeSOURCE Transplant Network® facilities)
Hearing Aids Contract Year Maximum: Unlimited **Note:** Includes testing and fitting of hearing aid devices at Physician Office Visit cost share.	100%

BENEFIT HIGHLIGHTS	IN-NETWORK
Hearing Services Physician's Office Visit **Note:** Routine Hearing Exam limited to one exam every 24 months.	No charge after the $20 PCP or applicable $30 Tier 1 or $40 non-Tier 1 Specialist per office visit copay
Durable Medical Equipment Contract Year Maximum: Unlimited	100%
Outpatient Dialysis Services	
Physician's Office Visit	No charge after the $20 PCP or $40 non-Tier 1 Specialist per office visit copay
Outpatient Facility **Note:** Non-surgical treatment procedures are not subject to the facility copay.	$100 per visit copay, then 100%
Physician's Services	100% (Tier 1) or 100% (non-Tier 1)
Home Setting	100%
Breast Feeding Equipment and Supplies **Note:** Includes the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.	No charge

BENEFIT HIGHLIGHTS	IN-NETWORK
External Prosthetic Appliances Contract Year Maximum: Unlimited	100%
Wigs Lifetime Per Maximum: Unlimited	100%
Diabetic Equipment and Supplies **Note:** Includes continuous glucose monitors and certain insulin products. For a list of covered products, contact Cigna Customer Service at the phone number on your ID card.	No charge
Nutritional Counseling Contract Year Maximum: Unlimited. Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services	 No charge after the $20 PCP or applicable $30 Tier 1 or $40 non-Tier 1 Specialist per office visit copay $200 per admission copay, then 100% $100 per visit copay, then 100% 100% (Tier 1) or 100% (non-Tier 1)
Nutritional Supplements Contract Year Maximum: Unlimited **Note:** Nutritional supplements that require a prescription (formulas and modified solid food products)	100%

BENEFIT HIGHLIGHTS	IN-NETWORK
Genetic Counseling Contract Year Maximum: 3 visits for counseling, pre- and post-genetic testing; however, the 3 visit limit does not apply to mental health and substance use disorder conditions.	
Physician's Office Visit	No charge after the $20 PCP or applicable $30 Tier 1 or $40 non-Tier 1 Specialist per office visit copay
Inpatient Facility	$200 per admission copay, then 100%
Outpatient Facility	$100 per visit copay, then 100%
Physician's Services	100% (Tier 1) or 100% (non-Tier 1)
Dental Care Limited to charges made for a continuous course of dental treatment for an Injury to teeth.	
Physician's Office Visit	No charge after the $20 PCP or applicable $30 Tier 1 or $40 non-Tier 1 Specialist per office visit copay
Inpatient Facility	$200 per admission copay, then 100%
Outpatient Facility	$100 per visit copay, then 100%
Physician's Services	100% (Tier 1) or 100% (non-Tier 1)
Massage Therapy Contract Year Maximum: 30 days **Note:** Coverage is provided subject to medical necessity and performed by a licensed therapist.	
Physician's Office Visit	No charge after the $20 PCP or $40 non-Tier 1 Specialist per office visit copay

BENEFIT HIGHLIGHTS	IN-NETWORK
Obesity/Bariatric Surgery **Note:** Coverage is provided subject to medical necessity and clinical guidelines subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section of this certificate. Includes coverage of bariatric surgery at approved centers. Excludes Lap-Band.	
Physician's Office Visit	No charge after the $20 PCP or applicable $30 Tier 1 or $40 non-Tier 1 Specialist per office visit copay
Inpatient Facility	$200 per admission copay, then 100%
Outpatient Facility	$100 per visit copay, then 100%
Physician's Services **Notes:** • Includes charges for surgeon only; does not include radiologist, anesthesiologist, etc.	100% (Tier 1) or 100% (non-Tier 1)
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary.
Travel Services Authorized travel and lodging expenses for designated covered services administered at an In-Network facility/provider when an In-Network facility/provider is not available within a 60-mile radius of your primary home residence not subject to any plan deductible. The following designated services are covered by your plan and may be eligible for this travel benefit: • all Medical and Mental Health and Substance Use Disorder services. **Lifetime Maximum for Travel and Lodging Expenses for Designated Services Combined** **Note:** Does not include other services with separate travel and lodging dollar maximum(s) as noted in The Schedule. Medical Benefit services other than Mental Health and Substance Use Disorder services: $10,000 Mental Health and Substance Use Disorder services: Unlimited	

BENEFIT HIGHLIGHTS	IN-NETWORK
Mental Health	
Inpatient Includes Acute Inpatient and Residential Treatment Contract Year Maximum: Unlimited	$200 per admission copay, then 100%
Outpatient	
Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, virtual care, etc. Contract Year Maximum: Unlimited	100%
Dedicated Virtual Providers MDLIVE Behavioral Services	100%
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), Transcranial Magnetic Stimulation (TMS), etc. Contract Year Maximum: Unlimited	100%

BENEFIT HIGHLIGHTS	IN-NETWORK
Substance Use Disorder	
Inpatient Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment Contract Year Maximum: Unlimited	Cigna: $200 per admission copay, then 100% COE: 100%
Outpatient	
Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, virtual care, etc. Contract Year Maximum: Unlimited	Cigna: 100% COE: 100%
Dedicated Virtual Providers MDLIVE Behavioral Services	100%
Outpatient - All Other Services Includes Outpatient Detoxification, Partial Hospitalization, Intensive Outpatient Services, etc. Contract Year Maximum: Unlimited	Cigna: 100% COE: 100%

Open Access Plus In-Network Medical Benefits

Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this plan.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services, except for 48/96 hour maternity stays.
- inpatient services at any participating Other Health Care Facility.
- residential treatment.
- outpatient facility services.
- advanced radiological imaging.
- non-emergency Ambulance.
- certain Medical Pharmaceuticals.
- home health care services.
- radiation therapy.
- transplant services.

Covered Expenses

The term Covered Expenses means expenses incurred by a person while covered under this plan for the charges listed below for:

- preventive care services; and
- services or supplies that are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna.

As determined by Cigna, Covered Expenses may also include all charges made by an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies listed below. **Any applicable Copayments, Deductibles or limits are shown in The Schedule.**

Covered Expenses

- charges for inpatient Room and Board and other Necessary Services and Supplies made by a Hospital, subject to the limits as shown in The Schedule.
- charges for inpatient Room and Board and other Necessary Services and Supplies made by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility as shown in The Schedule.
- charges for licensed Ambulance service to the nearest Hospital where the needed medical care and treatment can be provided.
- charges for outpatient medical care and treatment received at a Hospital.
- charges for outpatient medical care and treatment received at a Free-Standing Surgical Facility.
- charges for Emergency Services.
- charges for Urgent Care.
- charges by a Physician or a Psychologist for professional services.
- charges by a Nurse for professional nursing service.
- charges for anesthetics, including, but not limited to supplies and their administration.
- charges for diagnostic x-ray.
- charges for advanced radiological imaging, including for example CT Scans, MRI, MRA and PET scans and laboratory examinations, x-ray, radiation therapy and radium and radioactive isotope treatment and other therapeutic radiological procedures.
- charges for chemotherapy.
- charges for blood transfusions.
- charges for oxygen and other gases and their administration.
- charges for Medically Necessary foot care for diabetes, peripheral neuropathies, and peripheral vascular disease.
- charges for screening prostate-specific antigen (PSA) testing.
- charges for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected

contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).

- charges for Men's family planning, counseling, testing and sterilization (e.g. vasectomies).
- charges for the following preventive care services as defined by recommendations from the following:
  - the U.S. Preventive Services Task Force (A and B recommendations);
  - the Advisory Committee on Immunization Practices (ACIP) for immunizations;
  - the American Academy of Pediatrics' Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care;
  - the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and
  - with respect to women, evidence-informed preventive care and screening guidelines supported by the Health Resources and Services Administration.

  Detailed information is available at www.healthcare.gov. For additional information on immunizations, visit the immunization schedule section of www.cdc.gov.
- charges for surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).
- charges for acupuncture.
- charges for Medically Necessary blepharoplasty, homeopathic services and rhinoplasty
- charges for hearing aids and associated exam for device testing and fitting, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound. Benefits are also provided for certain over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss. Benefits for over-the-counter hearing aids do not require any of the following:
- A medical exam.
- A fitting by an audiologist.
- A written prescription.
- Medically Necessary orthognathic surgery to repair or correct a severe facial deformity or disfigurement.
- charges for services related to gender affirmation, including behavioral counseling, hormone therapy, genital reconstructive surgical procedures, and chest reconstructive surgical procedures. . Also covered: other facial masculinization and feminization procedures.

Virtual Care

Dedicated Virtual Providers

Includes charges for the delivery of real-time medical and health-related services, consultations and remote monitoring by dedicated virtual providers as medically appropriate through audio, video and secure internet-based technologies.

Includes charges for the delivery of mental health and substance use disorder-related services, consultations, and remote monitoring by dedicated virtual providers as appropriate through audio, video and secure internet-based technologies.

Virtual Physician Services

Includes charges for the delivery of real-time medical and health-related services, consultations and remote monitoring as medically appropriate through audio, video and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.

Includes charges for the delivery of real-time mental health and substance use disorder consultations and services, via secure telecommunications technologies that shall include video capability, telephone and internet, when such consultations and services are delivered by a behavioral provider and are similar to office visit services provided in a face-to-face setting.

Convenience Care Clinic

Convenience Care Clinics provide for common ailments and routine services, including but not limited to, strep throat, ear infections or pink eye, immunizations and flu shots.

Genetic Counseling

Charges for genetic counseling for an individual who is undergoing genetic testing or is a potential candidate for genetic testing. May be performed prior to and/or following the genetic test.

Nutritional Counseling

Charges for nutritional counseling when diet is a part of the medical management of a medical or behavioral condition.

Enteral Nutrition

Enteral Nutrition means medical foods that are specially formulated for enteral feedings or oral consumption.

Coverage includes medically approved formulas prescribed by a Physician for treatment of inborn errors of metabolism (e.g., disorders of amino acid or organic acid metabolism).

Internal Prosthetic/Medical Appliances

Charges for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for non-functional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

HC-COV1466 M 01-25

Obesity Treatment

- charges made for medical and surgical services only at approved centers for the treatment or control of clinically severe (morbid) obesity as defined below and if the services are demonstrated, through existing peer reviewed, evidence based, scientific literature and scientifically based guidelines, to be safe and effective for the treatment or control of the condition. Clinically severe (morbid) obesity is defined by the National Heart, Lung and Blood Institute (NHLBI) as a Body Mass Index (BMI) of 40 or greater without comorbidities, or a BMI of 35-39 with comorbidities. The following items are specifically excluded:
  - medical and surgical services to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of obesity or clinically severe (morbid) obesity; and
  - weight loss programs or treatments, whether or not they are prescribed or recommended by a Physician or under medical supervision.

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Gender Transition

Charges for services related to gender affirmation, including gender affirmation surgery. Coverage when applicable includes behavioral counseling, hormone therapy, genital reconstructive surgical procedures, and initial mastectomy or breast reduction and specific services including but not limited to breast augmentation with or without prosthetic implant; facial feminization surgery, thyroid cartilage reduction, and electrolysis epilation for the face and genitalia; and cosmetic services including abdominoplasty, removal of redundant skin, skin resurfacing (e.g. dermabrasion, chemical peels), calf implants, cheek/malar implants, chin/nose implants, collagen injections, forehead lift, hair transplantation, jaw reduction, testicular expander (including replacement of expander with permanent prosthesis), laryngoplasty, mastopexy, neck tightening, nipple/areola reconstruction, and unrelated to mastectomy or post-mastectomy reconstruction.

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Home Health Care Services

Charges for skilled care provided by certain health care providers during a visit to the home, when the home is determined to be a medically appropriate setting for the services.

Home Health Care Services are covered when skilled care is required under any of the following conditions:

- the required skilled care cannot be obtained in an outpatient facility.
- confinement in a Hospital or Other Health Care Facility is not required.
- the patient's home is determined by Cigna to be the most medically appropriate place to receive specific services.

Covered services include:

- skilled nursing services provided by a Registered Nurse (RN), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN) and an Advanced Practice Registered Nurse (APRN).
- services provided by health care providers such as physical therapist, occupational therapist and speech therapist.
- services of a home health aide when provided in direct support of those nurses and health care providers.
- necessary consumable medical supplies and home infusion therapy administered or used by a health care provider.

Note: Physical, occupational, and other Outpatient Therapy Services provided in the home are covered under the Outpatient Therapy Services benefit shown in The Schedule.

The following are excluded from coverage:

- services provided by a person who is a member of the patient's family, even when that person is a health care provider.

- services provided by a person who normally resides in the patient's house, even when that person is a health care provider.
- non-skilled care, Custodial Services, and assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other services; self-care activities; homemaker services; and services primarily for rest, domiciliary or convalescent care.

Home Health Care Services, for a patient who is dependent upon others for non-skilled care and/or Custodial Services, is provided only when there is a family member or caregiver present in the home at the time of the health care visit to provide the non-skilled care and/or Custodial Services.

HC-COV1123 M 01-22

Hospice Care Services

Charges for services for a person diagnosed with advanced illness having a life expectancy of twelve or fewer months. Services provided by a Hospice Care Program are available to those who have ceased treatment and to those continuing to receive curative treatment and therapies.

Hospice Care Programs rendered by Hospice Facilities or Hospitals include services:

- by a Hospice Facility for Room and Board and Services and Supplies;
- by a Hospice Facility for services provided on an outpatient basis;
- by a Physician for professional services;
- by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
- for pain relief treatment, including drugs, medicines and medical supplies;

Hospice Care Programs rendered by Other Health Care Facilities or in the Home include services:

- for part-time or intermittent nursing care by or under the supervision of a Nurse;
- for part-time or intermittent services of an Other Health Professional;
- physical, occupational and speech therapy;
- medical supplies;
- drugs and medicines lawfully dispensed only on the written prescription of a Physician;
- laboratory services;

but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- services for any period when you or your Dependent is not under the care of a Physician;
- services or supplies not listed in the Hospice Care Program;
- to the extent that any other benefits are payable for those expenses under the policy;
- services or supplies that are primarily to aid you or your Dependent in daily living.

HC-COV1180 01-22

Mental Health and Substance Use Disorder Services

The plan covers charges for mental health and substance use disorder services.

Mental Health Disorders are conditions which consider the following factors as defined in the current version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM):

- a behavioral or psychological syndrome or pattern that occurs in an individual.
- reflects an underlying psychobiological dysfunction.
- the consequences of which are clinically significant distress (such as a painful symptom) or disability (such as impairment in one or more important areas of functioning).
- must not be merely an expected response to common stressors and losses (such as loss of a loved one) or a culturally sanctioned response to a particular event (such as trance states in religious rituals).
- primarily a result of social deviance or conflicts with society.

Substance Use Disorders involve patterns of symptoms caused by using a substance that an individual continues taking despite its negative effects, considering the following factors as defined in the current version of the American

Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM):

- using more of a substance than intended or using it for longer than a person is meant to use it.
- trying to cut down or stop using the substance, but unable to do so.
- experiencing intense cravings or urges to use the substance.
- needing more of the substance to get a desired effect, also referred to as tolerance.
- developing withdrawal symptoms when not using the substance.
- spending more time getting and using drugs and recovering from substance use.
- neglecting responsibilities at home, work, or school because of substance use.
- continuing to use the substance despite the substance causing problems to physical or mental health.
- giving up important or desirable social and recreational activities due to substance use.
- using substances in risky settings that put you or your Dependent in danger.

Inpatient Mental Health Services (including Mental Health Acute Inpatient Services and Mental Health Residential Treatment Services)

Mental Health Acute Inpatient Services are services provided by a Hospital while you or your Dependent are Confined in a Hospital for evaluation and treatment of an acute Mental Health Disorder.

Mental Health Residential Treatment Services are services provided by a Hospital or Mental Health Residential Treatment Center while you or your Dependent are Confined in a Hospital or Residential Treatment Center for the evaluation and treatment of a subacute Mental Health Disorder.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of a Mental Health Disorder; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a Mental Health Residential Treatment Center.

Outpatient Mental Health Services (including Mental Health Partial Hospitalization and Mental Health Intensive Outpatient Services)

Outpatient Mental Health Services are services provided by providers who are licensed or certified in accordance with the laws of the appropriate legally authorized agency and qualified to treat Mental Health Disorders when treatment is provided on an outpatient basis, while you or your Dependent are not Confined in a Hospital or Mental Health Residential Treatment Center, for evaluation and treatment of a Mental Health Disorder.

Applied behavioral analysis (ABA) therapy is covered under the Mental Health Outpatient - All Other benefit.

Mental Health Partial Hospitalization Services are active, time-limited, ambulatory mental health treatment programs that offer therapeutically intensive, structured, and coordinated clinical services for Mental Health Disorders, similar in intensity to that provided in an Inpatient Hospital or Mental Health Residential Treatment Center, but for individuals who can maintain personal safety with support systems in the community.

Mental Health Intensive Outpatient Services are active, time-limited, ambulatory mental health treatment programs that offer structured and coordinated, multi-disciplinary clinical services for Mental Health Disorders for individuals who can maintain personal safety with support systems in the community, and who can maintain some ability to fulfill family, student or work activities.

Inpatient Substance Use Disorder Services (including Acute Inpatient Detoxification, Substance Use Disorder Inpatient Rehabilitation, Substance Use Disorder Residential Treatment Services)

Acute Inpatient Detoxification Services are services provided by a Hospital or Substance Use Disorder Residential Treatment Center for around-the-clock, intensive management and monitoring of individuals requiring acute detoxification as the initial phase of evaluation and treatment for a Substance Use Disorder.

Substance Use Disorder Inpatient Treatment Services are services provided by a Hospital while you or your Dependent are Confined in a Hospital for evaluation and treatment of an acute Substance Use Disorder.

Substance Use Disorder Residential Treatment Services are services provided by a Hospital or Substance Use Disorder Residential Treatment Center while you or your Dependent are Confined in a Hospital or Residential Treatment Center for

evaluation and treatment of a subacute Substance Use Disorder.

Substance Use Disorder Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of a Substance Use Disorder; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a Substance Use Disorder Residential Treatment Center.

Outpatient Substance Use Disorder Rehabilitation Services (including Outpatient Detoxification, Substance Use Disorder Partial Hospitalization, and Substance Use Disorder Intensive Outpatient Services)

Outpatient Substance Use Disorder Services are services provided by providers who are licensed or certified in accordance with the laws of the appropriate legally authorized agency and qualified to treat Substance Use Disorders when treatment is provided on an outpatient basis, while you or your Dependent are not Confined in a Hospital or Substance Use Disorder Residential Treatment Center, for evaluation and treatment of a Substance Use Disorder.

Methadone maintenance is covered, including pain management for M/S conditions and methadone treatment for opioid use.

Substance Use Disorder Partial Hospitalization Services are active, time-limited, ambulatory substance use disorder treatment programs that offer therapeutically intensive, structured, and coordinated clinical services for Substance Use Disorders, similar in intensity to that provided in an Inpatient Hospital or Substance Use Disorder Residential Treatment Center, but for individuals who can maintain personal safety with support systems in the community.

Substance Use Disorder Intensive Outpatient Services are active, time-limited, ambulatory substance use disorder treatment programs that offer structured and coordinated, multi-disciplinary clinical services for Substance Use Disorders for individuals who can maintain personal safety with support systems in the community, and who can maintain some ability to fulfill family, student or work activities.

Substance Use Disorder Detoxification Services are services provided for daily, active comprehensive management and monitoring of individuals requiring detoxification as part of evaluation and treatment of a Substance Use Disorder, but that do not require a person to be Confined in a Hospital or Substance Use Disorder Residential Treatment Center.

Durable Medical Equipment

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, ventilators, insulin pumps and wheel chairs.

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers and air purifiers.

- **Other Equipment:** centrifuges, needleless injectors, heat lamps, heating pads, cryounits, cryotherapy machines, ultraviolet cabinets, that emit Ultraviolet A (UVA) rays sheepskin pads and boots, postural drainage board, AC/DC adaptors, scales (baby and adult), stair gliders, elevators, saunas, cervical and lumbar traction devices, exercise equipment and diathermy machines.

HC-COV1124 02-21

External Prosthetic Appliances and Devices

- charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect.

External prosthetic appliances and devices include prostheses/prosthetic appliances and devices; orthoses and orthotic devices; braces; and splints.

Prostheses/Prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- limb prostheses;
- terminal devices such as hands or hooks;
- speech prostheses; and
- facial prostheses.

Orthoses and Orthotic Devices

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Non-foot orthoses – only the following non-foot orthoses are covered:
  - rigid and semi-rigid custom fabricated orthoses;
  - semi-rigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
  - cranial banding and/or cranial orthoses when approved as medically necessary based on Cigna guidelines.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- non-foot orthoses primarily used for cosmetic rather than functional reasons; and
- non-foot orthoses primarily for improved athletic performance or sports participation.

Braces

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded: Copes scoliosis braces.

Splints

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- replacement required because anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

- replacement due to a surgical alteration or revision of the impacted site.

Coverage for replacement is limited as follows:

- no more than once every 24 months for persons 19 years of age and older.
- no more than once every 12 months for persons 18 years of age and under.

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements for external prosthetic devices; or
- microprocessor controlled prostheses and orthoses; and
- myoelectric prostheses and orthoses.

HC-COV1125 01-22
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Infertility Services

Covered expenses include the following services when medical assistance is needed for an enrolled member to have a baby, regardless of relationship status, sexual orientation, or gender identity:

- diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed.
- access to reproductive services for the purposes of short-term fertility preservation.

Services include, but are not limited to: injectable fertility drugs which are administered or provided by a Physician; retrieval, cryopreservation, storage, and thawing of sperm and eggs; approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; intrauterine insemination/artificial insemination; diagnostic evaluations; assisted reproductive techniques (ART) including in vitro fertilization (IVF); and the services of an embryologist.

The treatment approach is limited to the least invasive and lowest cost as guided by the provider for a successful pregnancy.

This benefit includes diagnosis and treatment of both male and female infertility and fertility preservation services.

The following are specifically excluded infertility services:

- oral fertility drugs;
- infertility services when the infertility is caused by or related to voluntary sterilization;
- donor charges, donor services, and donor eggs, sperm, and embryos;
- infertility services for the purpose of being a surrogate or creating a baby other than for the enrolled members' immediate family;
- services of an individual or agency for a surrogate and/or adoption.

HC-COV1653 M 07-25

Outpatient Therapy Services

Charges for the following therapy services:

Cognitive Therapy, Occupational Therapy, Osteopathic Manipulation, Physical Therapy, Pulmonary Rehabilitation, Speech Therapy

- Charges for therapy services are covered when provided as part of a program of treatment.

Cardiac Rehabilitation

- Charges for Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge. The Phase II program must be Physician directed with active treatment and EKG monitoring.

  Phase III and Phase IV cardiac rehabilitation is not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.

Chiropractic Care Services

- Charges for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services you have direct access to qualified chiropractic Physicians.

Coverage is provided when Medically Necessary in the most medically appropriate setting to:

- Restore function (called "rehabilitative"):
  - To restore function that has been impaired or lost.
  - To reduce pain as a result of Sickness, Injury, or loss of a body part.
- Improve, adapt or attain function (sometimes called "habilitative"):
  - To improve, adapt or attain function that has been impaired or was never achieved as a result of congenital abnormality (birth defect).
  - To improve, adapt or attain function that has been impaired or was never achieved because of mental health and substance use disorder conditions. Includes conditions such as autism and intellectual disability, or mental health and substance use disorder conditions that result in a developmental delay.

Coverage is provided as part of a program of treatment when the following criteria are met:

- The individual's condition has the potential to improve or is improving in response to therapy, and maximum improvement is yet to be attained.
- There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- The therapy is provided by, or under the direct supervision of, a licensed health care professional acting within the scope of the license.
- The therapy is Medically Necessary and medically appropriate for the diagnosed condition.

Coverage for occupational therapy is provided only for purposes of enabling individuals to perform the activities of daily living after an Injury or Sickness.

Therapy services that are not covered include:

- sensory integration therapy.
- treatment of dyslexia.
- maintenance or preventive treatment provided to prevent recurrence or to maintain the patient's current status.
- charges for Chiropractic Care not provided in an office setting.
- vitamin therapy.

Coverage is administered according to the following:

- Multiple therapy services provided on the same day constitute one day of service for each therapy type.
- A separate Copayment applies to the services provided by each provider for each therapy type per day.

HC-COV982 01-21

Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance; postoperative breast prostheses; and mastectomy bras and prosthetics, limited to the lowest cost alternative available that meets prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

HC-COV631 12-17

Transplant Services and Related Specialty Care

Charges approved by medical management for human organ and tissue transplant services including solid organ and bone marrow/stem cell procedures at Cigna LifeSOURCE Transplant Network® facilities throughout the United States or its territories subject to the following conditions and limitations.

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral. Implantation procedures for artificial heart, percutaneous ventricular assist device (PVAD), extracorporeal membrane oxygenation (ECMO) ventricular assist device (VAD) and intra-aortic balloon pump (IABP) are also covered.

- All transplant services and related specialty care services, other than cornea transplants, must be received at a Cigna LifeSOURCE Transplant Network® facility. Transplant services and related specialty care services received at any other facility are not covered.
- Cornea transplants received at a facility that is specifically contracted with Cigna for this type of transplant are payable at the In-Network level.

Charges for gene therapy products and services directly related to their administration are not covered under the Transplant Services and Related Specialty Care benefit.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of hospitalization and surgery necessary for removal of an organ and transportation of a live donor (refer to Transplant and Related Specialty Care Travel Services). Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant and Related Specialty Care Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations:

- Transplant and related specialty care travel benefits are not available for cornea transplants.
- Benefits for transportation and lodging are available to the recipient of a preapproved organ/tissue transplant and/or related specialty care from a designated Cigna LifeSOURCE Transplant Network® facility.
- The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care.
- Travel expenses for the person receiving the transplant will include charges for: transportation to and from the designated Cigna LifeSOURCE Transplant Network® facility (including charges for a rental car used during a period of care at the designated Cigna LifeSOURCE Transplant Network® facility); and lodging while at or traveling to and from the designated Cigna LifeSOURCE Transplant Network® facility.
- In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.
- The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits for Transplant Services and Related Specialty Care, and for Transplant and Related Specialty Care Travel Services are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above.

Charges for the expenses of a donor companion are not covered. No transplant and related specialty care services or travel benefits are available when the covered person is the donor for an organ/tissue transplant, the transplant recipient's plan would cover all donor costs.

HC-COV1483 01-24

Advanced Cellular Therapy

Charges for advanced cellular therapy products and services directly related to their administration are covered when Medically Necessary. Coverage includes the cost of the advanced cellular therapy product; medical, surgical, and facility services directly related to administration of the advanced cellular therapy product, and professional services.

Cigna determines which U.S. Food and Drug Administration (FDA) approved products are in the category of advanced cellular therapy, based on the nature of the treatment and how it is manufactured, distributed and administered. An example of advanced cellular therapy is chimeric antigen receptor (CAR) T-cell therapy that redirects a person's T cells to recognize and kill a specific type of cancer cell.

Advanced cellular therapy products and their administration are covered at the In-Network benefit level when prior authorized to be received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services. Advanced cellular therapy products and their administration received from a provider that is not contracted with Cigna for the specific advanced cellular therapy product and related services are not covered.

Advanced Cellular Therapy Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized advanced cellular therapy product are covered, subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when:

- you are the recipient of a prior authorized advanced cellular therapy product;
- the term recipient is defined to include a person receiving prior authorized advanced cellular therapy related services during any of the following: evaluation, candidacy, event, or post care;
- the advanced cellular therapy products and services directly related to their administration are received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services; and
- the provider is not available within a 60 mile radius of your primary home residence.

Travel expenses for the person receiving the advanced cellular therapy include charges for: transportation to and from the advanced cellular therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.

The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within a 60 mile radius of your primary home residence; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

HC-COV1327 04-23

Medical Pharmaceuticals

The plan covers charges made for Medical Pharmaceuticals that are administered in an Inpatient setting, Outpatient setting, Physician's office, or in a covered person's home.

Benefits under this section are provided only for Medical Pharmaceuticals which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified Physician or Other Health Professional. Benefits payable under this section include Medical Pharmaceuticals whose administration may initially, or typically, require Physician or Other Health Professional oversight but may be self-administered under certain conditions specified in the product's FDA labeling.

Certain Medical Pharmaceuticals are subject to prior authorization requirements or other coverage conditions. Additionally, certain Medical Pharmaceuticals are subject to step therapy requirements. This means that in order to receive benefits for such Medical Pharmaceuticals, you are required to try a different Medical Pharmaceutical and/or Prescription Drug Product first.

Utilization management requirements or other coverage conditions are based on a number of factors, which may include clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of Medical Pharmaceuticals as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Medical Pharmaceutical's cost including, but not limited to, assessments on the cost effectiveness of the Medical Pharmaceuticals and available rebates. Regardless of its eligibility for coverage under your plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you (or your Dependent) and the prescribing Physician.

The coverage criteria for a Medical Pharmaceutical may change periodically for various reasons. For example, a Medical Pharmaceutical may be removed from the market, a new Medical Pharmaceutical in the same therapeutic class as a Medical Pharmaceutical may become available, or other market events may occur. Market events that may affect the coverage status of a Medical Pharmaceutical include, but are not limited to, an increase in the cost of a Medical Pharmaceutical.

HC-COV1168 01-22

Gene Therapy

Charges for gene therapy products and services directly related to their administration are covered when Medically Necessary. Gene therapy is a category of pharmaceutical products approved by the U.S. Food and Drug Administration (FDA) to treat or cure a disease by:

- replacing a disease-causing gene with a healthy copy of the gene.
- inactivating a disease-causing gene that may not be functioning properly.
- introducing a new or modified gene into the body to help treat a disease.

Each gene therapy product is specific to a particular disease and is administered in a specialized manner. Cigna determines which products are in the category of gene therapy, based in part on the nature of the treatment and how it is distributed and administered.

Coverage includes the cost of the gene therapy product; medical, surgical, and facility services directly related to administration of the gene therapy product; and professional services.

Gene therapy products and their administration are covered when prior authorized to be received at In-Network facilities specifically contracted with Cigna for the specific gene therapy service. Gene therapy products and their administration received at other facilities are not covered.

Gene Therapy Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized gene therapy procedure are covered subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when you are the recipient of a prior authorized gene therapy; and when the gene therapy products and services directly related to their administration are received at a participating In-Network facility specifically contracted with Cigna for the specific gene therapy service. The term recipient is defined to include a person receiving prior authorized gene therapy related services during any of the following: evaluation, candidacy, event, or post care.

Travel expenses for the person receiving the gene therapy include charges for: transportation to and from the gene therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.

The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

HC-COV873 01-20

Clinical Trials

This plan covers routine patient care costs and services related to an approved clinical trial for a qualified individual. The individual must be eligible to participate according to the trial protocol and **either** of the following conditions must be met:

- the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate; or
- the individual provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

In addition to qualifying as an individual, the clinical trial must also meet certain criteria in order for patient care costs and services to be covered.

The clinical trial must be a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention,

detection, or treatment of cancer or other life-threatening disease or condition that meets **any** of the following criteria:

- it is a federally funded trial. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH).
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Health Care Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA).
  - a qualified non-governmental research entity identified in NIH guidelines for center support grants.
  - any of the following: Department of Energy, Department of Defense, Department of Veterans Affairs, if **both** of the following conditions are met:
    - the study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and
    - the study or investigation assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
  - the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA).
  - the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The plan does not cover any of the following services associated with a clinical trial:

- services that are not considered routine patient care costs and services, including the following:
  - the investigational drug, device, item, or service that is provided solely to satisfy data collection and analysis needs.
  - an item or service that is not used in the direct clinical management of the individual.
  - a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
  - an item or service provided by the research sponsors free of charge for any person enrolled in the trial.
- travel and transportation expenses, unless otherwise covered under the plan, including but not limited to the following:
  - fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline, train.
  - mileage reimbursement for driving a personal vehicle.
  - lodging.
  - meals.
- routine patient costs obtained out-of-network when Out-of-Network benefits do not exist under the plan.

Examples of routine patient care costs and services include:

- radiological services.
- laboratory services.
- intravenous therapy.
- anesthesia services.
- Physician services.
- office services.
- Hospital services.
- Room and Board, and medical supplies that typically would be covered under the plan for an individual who is not enrolled in a clinical trial.

HC-COV1128 01-22

Travel Services

Charges for non-taxable travel and lodging expenses incurred by you and one accompanying Companion/Caregiver (or up to two caregivers for a Dependent minor) are covered in connection with designated services.

Travel services for a designated covered service may be authorized for coverage when an In-Network facility/provider is not available within a 60-mile radius of your primary home residence. Travel and lodging expenses are covered for designated services administered at a participating In-Network facility/provider, subject to the maximum shown in The Schedule.

Travel is available for the following designated services when covered by your plan:

- all Medical and Mental Health and Substance Use Disorder services.

Pre-authorization of travel is required by contacting Cigna at the number on the back of your ID card. Pre-authorization of the covered designated service also may be required.

The Companion/Caregiver can be your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.

Actual reimbursement is subject to specific plan or benefits terms. These guidelines are designed to help the participant and covered dependents become more aware of expenses that may be reimbursable. Expenses must be submitted within 1 year of occurrence. However, if benefits terminate, you must submit any remaining expenses within 30 days of the date of termination of your benefits.

Covered travel expenses are reimbursed within daily limits as defined by the Internal Revenue Service and include charges for:

- airfare (coach or economy), including baggage fees.
- bus fare, train fare, taxi/Uber/Lyft, etc.
- vehicle rentals.
- gasoline.
- highway tolls (not prepaid).
- parking.
- Round-trip airfare within the US
- shuttle services.
- wheelchair van service to travel from local housing to facility/provider.

Lodging Expenses

- lodging up to $50 per night, per person for up to two people (maximum of $100 per night, inclusive of taxes and nonrefundable fees), including but not limited to: hotel, motel, rental from businesses such as Airbnb, VRBO, etc.
- Temporary residence–furniture rental must be approved in advance by your case manager. Furniture rental and utilities are included in the daily maximum for lodging and are covered only when used at the temporary residence. Utilities include water, electric and gas ONLY (including propane for heating or cooking).
- Housing associated with the treating facilities
- Hotel, motel
- Other commercially rented lodging such as apartments, condominiums, Ronald McDonald House, campgrounds, recreational vehicles or extended stay facilities

Non-Covered Lodging Expenses

- Cable/satellite television services
- Comfort and convenience items such as weight scales)
- Deposits for housing, utilities, etc.
- Dry cleaning or laundry services
- Household products (cleaning supplies, paper towels, towels, etc.)
- Internet service
- Minibar items
- Packing materials
- Rental of private residence–the owner of the residence must have a Taxpayer Identification Number and the rental must be commercially available through a vendor such as Airbnb, VRBO, etc.
- Room service
- Telephones or phone services
    - cell phone and landlines (including hotel phone charges).
- Toiletries (personal hygiene items, diapers, toilet paper, etc.)
- Any item(s) not listed as covered

Excluded travel expenses include but are not limited to the following:

- any expenses that if reimbursed would be taxable income.
- Fines or traffic tickets, Court or other loss or damage resulting from traffic violations or incidents
- First-class airline rates, or any rates that exceed coach or economy
- Food/Meals/Snacks/Beverages
- Loss of money or loss/damage to luggage, clothing or other items
- Pet care including, but not limited to, pet kennel, boarding, pet sitting, pet care items and pet transportation fees
- Tires
- Travel from outside the United States

- Travel or other personal trip insurance
- Travel to locations other than the medical center or your home (or other temporary housing)
- Vehicle expenses such as:
    - Maintenance (including oil changes)
- Deposits for rental
    - Repairs fro any vehicle
    - Insurance for personal or rental
- Any item(s) not listed as covered
- travel within the mile radius defined above of your primary home residence.
- food and meals.
- mileage.
- incidentals, including but not limited to: laundry bills, telephone bills, alcohol or tobacco products.
- charges for transportation that exceed coach class rates.
- durable medical equipment, medical supplies.
- Prescription medications
- Ambulance (air or ground)
- refundable deposits for housing, utilities, etc.
- travel for services not designated above.
- services that are not covered by the plan.
- Any services or out-of-pocket expenses covered under your medical benefit plan including, but not limited to:
- Barber beautician, manicurist, shoe shine, massage services, tanning salons, etc.
- Childcare
- Clothing or shoes of any kind
- Entertainment items–books, magazines, movie or theater tickets, movie rentals, admission to attractions (zoo, amusement park, etc.)
- Gift cards

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

Additional coverage limitations determined by plan or provider type are shown in The Schedule. Payment for the following is specifically excluded from this plan:

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- charges which you are not obligated to pay and/or for which you are not billed. This exclusion includes, but is not limited to:
    - any instance where Cigna determines that a provider or Pharmacy did not bill you for or has waived, reduced, or forgiven any portion of its charges and/or any portion of any Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for an otherwise Covered Expense (as shown on The Schedule) without Cigna's express consent.
    - charges of a non-Participating Provider who has agreed to charge you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received.

  In the event that Cigna determines that this exclusion applies, then Cigna in its sole discretion shall have the right to:
    - require you and/or any provider or Pharmacy submitting claims on your behalf to provide proof sufficient to Cigna that you have made your required cost-share payment(s) prior to the payment of any benefits by Cigna;
    - deny the payment of benefits in connection with the Covered Expense regardless of whether the provider or the Pharmacy represents that you remain responsible for any amounts that your plan does not cover; or
    - reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain

responsible for any amounts that your plan does not cover.

- charges or payment for healthcare-related services that violate state or federal law.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be either:

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for any indication; or
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing any condition or Sickness regardless of U.S. Food and Drug Administration (FDA) approval status.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician relies on the coverage policies maintained by Cigna or the Review Organization. Coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.
- charges for health care services, supplies, or medications when billed for conditions or diagnoses that are not covered or reimbursable under the coverage policies maintained by Cigna or the Review Organization.
- cosmetic surgery and therapies, except for services noted in Covered Expenses under Gender Transition. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- the following services are excluded from coverage regardless of clinical indications except as may be covered under the "Reconstructive Surgery" benefit and "Gender Affirmation" services: redundant skin surgery; removal of skin tags; acupressure; craniosacral and cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for a continuous course of dental treatment for an Injury to teeth are covered.
- for medical and surgical services intended primarily for the treatment or control of obesity, which are not Medically Necessary. Excluded services include, but are not limited to, weight reduction procedures designed to restrict your ability to assimilate food, such as gastric bypass, gastric balloons, jaw wiring, stomach stapling and jejunal bypass.
- reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations, unless otherwise covered under this plan.
- court-ordered treatment or hospitalization, unless treatment is prescribed by a Physician and is a covered service or supply under this plan.
- any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the child of your Dependent child, unless the child is otherwise eligible under this plan.
- non-medical counseling and/or ancillary services, including but not limited to Custodial Services, educational services, vocational counseling, training and, rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- non-medical living arrangements, including but not limited to, health resorts, recreational programs, outdoor skills programs, relaxation or lifestyle programs, or supportive living programs.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of

enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Care Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Care Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and dentures.
- aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- eyeglass lenses and frames, contact lenses and associated services (exams and fittings) (except for the initial set after treatment of keratoconus or following cataract surgery).
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- all non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies and peripheral vascular disease are covered when Medically Necessary.
- membership costs and fees associated with health clubs, weight loss programs or smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection, storage or donation of blood or blood products, except for autologous donation in anticipation of scheduled services when medical management review determines the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are medications for the purpose of travel, or to protect against occupational hazards and risks.
- health and beauty aids, cosmetics and dietary supplements.
- enteral feedings whether prescribed or not except for infant formula needed for the treatment of inborn errors of metabolism.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- charges related to an Injury or Sickness payable under worker's compensation or similar laws.
- expenses incurred by a participant to the extent reimbursable under automobile insurance coverage. Coverage under this plan is secondary to automobile no-fault insurance or similar coverage. The coverage provided under this plan does not constitute "Qualified Health Coverage" under Michigan law and therefore does not replace Personal Injury Protection (PIP) coverage provided under an automobile insurance policy issued to a Michigan resident. This plan will cover expenses only not otherwise covered by the PIP coverage.

General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents:

- for charges by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.

- for any charges related to care provided through a public program, other than Medicaid.
- for charges which would not have been made if the person did not have coverage.
- to the extent that they are more than Maximum Reimbursable Charges applicable to care, if any, received Out-of-Network.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- for expenses for services, supplies, care, treatment, drugs or surgery that are not Medically Necessary.
- for charges made by any Physician or Other Health Professional who is a member of your family or your Dependent's family.
- for expenses incurred outside the United States other than expenses for Medically Necessary emergency or urgent care while temporarily traveling abroad.
- wilderness therapy, health resorts, recreational programs, outdoor skills programs, relaxation or lifestyle programs, and services provided in conjunction with or as part of those programs.

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Coverage under this Plan plus another Plan will not guarantee 100% reimbursement.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public nor is individually underwritten including closed panel coverage.
- Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and which limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service if rendered under similar or comparable circumstances by other health care providers located within the immediate geographic area where the health care service was delivered.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers a person as an enrollee or an employee shall be the Primary Plan and the Plan that covers that person as a Dependent shall be the Secondary Plan;
- For a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year;

- For the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the noncustodial parent of the child; and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, the benefits that would be payable under this Plan in the absence of Coordination will be reduced by the benefits payable under all other Plans for the expense covered under this Plan.

When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service rendered will be considered both an expense incurred and a benefit payable.

Recovery of Excess Benefits

If Cigna pays charges for services and supplies that should have been paid by the Primary Plan, Cigna will have the right to recover such payments.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments were made by any insurance company, healthcare plan or other organization. If we request, you shall execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 55 days of the request, the claim will be closed. If the requested information is subsequently received, the claim will be processed.

Medicare Eligibles

Cigna will pay as the Secondary Plan as permitted by the Social Security Act of 1965 as amended for the following:

(a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this Plan;

(b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this Plan;

(c) an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100

Employees and that Employee is eligible for Medicare due to disability;

(d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;

(e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;

(f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

Cigna will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This reduction will not apply to any Employee and his Dependent or any former Employee and his Dependent unless he is listed under (a) through (f) above.

Domestic Partners

Under federal law, the Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health Plan when Medicare coverage is due to age. Therefore, when Medicare coverage is due to age, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and Cigna is the Secondary Plan. However, when Medicare coverage is due to disability, the Medicare Secondary Payer Rules explained above will apply.

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage. The coverage under this plan is secondary to any automobile no-fault insurance or similar coverage.

Subrogation/Right of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

- Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan’s subrogation rights.
- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

Lien of the Plan

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said

attorney, insurance carrier or other party has been notified by the plan or its agents;

- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- The plan hereby disavows all equitable defenses in pursuit of its right of recovery. The plan's subrogation or recovery rights are neither affected nor diminished by equitable defenses.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Participants must assist the plan in pursuing any subrogation or recovery rights by providing requested information.

HC-SUB128 03-20

Payment of Benefits

Assignment and Payment of Benefits

You may not assign to any party, including, but not limited to, a provider of healthcare services/items, your right to benefits under this plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have under ERISA, including, but not limited to, any right to make a claim for plan benefits, to request plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights shall be void and unenforceable under all circumstances.

You may, however, authorize Cigna to pay any healthcare benefits under this policy to a Participating or Non-Participating Provider. When you authorize the payment of your healthcare benefits to a Participating or Non-Participating Provider, you authorize the payment of the entire amount of the benefits due on that claim. If a provider is overpaid because of accepting duplicate payments from you and Cigna, it is the provider's responsibility to reimburse the overpayment to you. Cigna may pay all healthcare benefits for Covered Expenses directly to a Participating Provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare

benefits to a Participating or Non-Participating Provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a provider of healthcare services/items.

Even if the payment of healthcare benefits to a Non-Participating Provider has been authorized by you, Cigna may, at its option, make payment of benefits to you. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the Non-Participating Provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment. In addition, your acceptance of benefits under this plan and/or assignment of Medical Benefits separately creates an equitable lien by agreement pursuant to which Cigna may seek recovery of any overpayment. You agree that Cigna, in seeking recovery of any overpayment as a contractual right or as an equitable lien by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

Calculation of Covered Expenses

Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology.
- the methodologies as reported by generally recognized professionals or publications.

HC-POB132 01-19

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is cancelled.
- the last day of the calendar month in which your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date as determined by your Employer.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, your insurance will not continue past the date your Employer cancels your insurance.

Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is cancelled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

HC-TRM128 12-17

Rescissions

Your coverage may not be rescinded (retroactively terminated) by Cigna or the plan sponsor unless the plan sponsor or an individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud; or the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

HC-TRM80 01-11

Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

HC-FED1 10-10

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

A list of network providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, affiliated or contracted with Cigna or an organization contracting on its behalf.

HC-FED78 10-10

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial

parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

HC-FED4 10-10

Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option. The special enrollment events include:

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage.
- **Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
  - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
  - the other plan no longer offers any benefits to a class of similarly situated individuals.
- **Termination of Employer contributions (excluding continuation coverage).** If a current or former Employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to failure of the Employer or other responsible entity to remit premiums on a timely basis; when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an Employer's limited period of

contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

- **Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 31 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective no later than the first day of the first calendar month following receipt of the request for special enrollment.

Domestic Partners and their children (if not legal children of the Employee) are not eligible for special enrollment.

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed:

- if you meet Special Enrollment criteria and enroll as described in the Special Enrollment section; or
- if your Employer agrees, and you meet the criteria shown in the following Sections B through H and enroll for or change coverage within the time period established by your Employer.

B. Change of status

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

C. Court order

A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

D. Medicare or Medicaid eligibility/entitlement

The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

E. Change in cost of coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in coverage of spouse or Dependent under another employer's plan

You may make a coverage election change if the plan of your spouse or Dependent: incurs a change such as adding or deleting a benefit option; allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or this Plan and

the other plan have different periods of coverage or open enrollment periods.

G. Reduction in work hours

If an Employee's work hours are reduced below 30 hours/week (even if it does not result in the Employee losing eligibility for the Employer's coverage); and the Employee (and family) intend to enroll in another plan that provides Minimum Essential Coverage (MEC). The new coverage must be effective no later than the 1st day of the 2nd month following the month that includes the date the original coverage is revoked.

H. Enrollment in a Qualified Health Plan (QHP)

Employee: The Employee must be eligible for a Special Enrollment Period to enroll in a QHP through an Exchange (Marketplace) or the Employee seeks to enroll in a QHP through an Exchange during the Marketplace's annual open enrollment period; and the disenrollment from the group plan corresponds to the intended enrollment of the Employee (and family) in a QHP through an Exchange for new coverage effective beginning no later than the day immediately following the last day of the original coverage.

Family: A plan may allow an Employee to revoke family coverage midyear in order for family members ("related individuals") to enroll in a QHP through an Exchange (Marketplace). The related individual(s) must be eligible for a Special Enrollment Period to enroll in a QHP or seek to enroll in a QHP during the Marketplace's annual open enrollment period, and the disenrollment from the group plan corresponds to the intended enrollment of the individual(s) in a QHP for new coverage effective beginning no later than the day immediately following the last day of the original coverage. If the Employee does not enroll in a QHP, the Employee must select self-only coverage or family coverage including one or more already-covered individuals.

HC-FED112 01-23

Eligibility for Coverage for Adopted Children

Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance, if otherwise eligible as a Dependent, upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exception for Newborns" section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

HC-FED67 09-14

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under a federal law known as the "Newborns' and Mothers' Health Protection Act": restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

HC-FED11 10-10

Women's Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

HC-FED12 10-10

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

HC-FED13 10-10

Requirements of Family and Medical Leave Act of 1993 (as amended) (FMLA)

Any provisions of the policy that provide for: continuation of insurance during a leave of absence; and reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, as amended, where applicable:

Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993, as amended.

HC-FED93 10-17

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

You may continue benefits by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

HC-FED18 10-10

Claim Determination Procedures under ERISA

The following complies with federal law. Provisions of applicable laws of your state may supersede.

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical Necessity determinations are made on a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. The booklet describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care professional) must request prior authorization according to the procedures described below, in the booklet, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not covered, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the booklet, in your provider's network participation documents as applicable, and in the determination notices.

Note: An oral statement made to you by a representative of Cigna or its designee that indicates, for example, a particular service is a Covered Expense, is authorized for coverage by the plan, or that you are eligible for coverage is not a guarantee that you will receive benefits for services under this plan. Cigna will make a benefit determination after a claim is received from you or your authorized representative, and the benefit determination will be based on, your eligibility as of the date services were rendered to you and the terms and conditions of the plan in effect as of the date services were rendered to you.

Preservice Determinations

When you or your representative requests a required prior authorization, Cigna will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna's control, Cigna will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a health care professional with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna will defer to the determination of the treating health care professional regarding whether an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request.

However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative attempts to request a preservice determination, but fails to follow Cigna's procedures for requesting a required preservice determination, Cigna will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

Concurrent Determinations

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent coverage determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, Cigna will notify you or your representative of the determination within 24 hours after receiving the request.

Postservice Determinations

When you or your representative requests a coverage determination or a claim payment determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control, Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: information sufficient to identify the claim including, if applicable, the date of service, provider and claim amount; diagnosis and treatment codes, and their meanings; the specific reason or reasons for the adverse determination including, if applicable, the denial code and its meaning and a description of any standard that was used in the denial; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal, (if applicable); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim; and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; a description of any available internal appeal and/or external review process(es); information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

HC-FED104 01-19

Appointment of Authorized Representative

You may appoint an authorized representative to assist you in submitting a claim or appealing a claim denial. However, Cigna may require you to designate your authorized representative in writing using a form approved by Cigna. At all times, the appointment of an authorized representative is revocable by you. To ensure that a prior appointment remains valid, Cigna may require you to re-appoint your authorized representative, from time to time.

Cigna reserves the right to refuse to honor the appointment of a representative if Cigna reasonably determines that:

- the signature on an authorized representative form may not be yours, or
- the authorized representative may not have disclosed to you all of the relevant facts and circumstances relating to the overpayment or underpayment of any claim, including, for example, that the billing practices of the provider of medical services may have jeopardized your coverage through the waiver of the cost-sharing amounts that you are required to pay under your plan.

If your designation of an authorized representative is revoked, or Cigna does not honor your designation, you may appoint a new authorized representative at any time, in writing, using a form approved by Cigna.

HC-FED88 01-17

Medical - When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you" or "your" also refers to a representative or provider designated by you to act on your behalf; unless otherwise noted.

We want you to be completely satisfied with the services you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start With Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you may call the toll-free number on your ID card, explanation of benefits, or claim form and explain your concern to one of our Customer Service representatives. You may also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Internal Appeals Procedure

To initiate an appeal of an adverse benefit determination, you must submit a request for an appeal to Cigna within 180 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal.

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call or write us at the toll-free number on your ID card, explanation of benefits, or claim form.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

We will respond in writing with a decision within 30 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination or a postservice Medical Necessity determination. We will respond within 60 calendar days after we receive an appeal for any other postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, this information will be provided automatically to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You may request that the appeal process be expedited if the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your health care provider would cause you severe pain which cannot be managed without the requested services.

If you request that your appeal be expedited, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to your medical condition.

When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

External Review Procedure

Any external review procedure available under the plan will apply to any adverse determination regarding whether the plan complied with the surprise billing and cost sharing protections of the federal No Surprises Act and its implementing regulations.

If you are not fully satisfied with the decision of Cigna's internal appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization (IRO). The IRO is composed of persons who are not employed by Cigna, or any of its affiliates. A decision to request an external review to an IRO will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate an external review. Cigna and your benefit plan will abide by the decision of the IRO.

To request a review, you must notify the Appeals Coordinator within 4 months of your receipt of Cigna's appeal review denial. Cigna will then forward the file to a randomly selected IRO. The IRO will render an opinion within 45 days.

When requested, and if a delay would be detrimental to your medical condition, as determined by Cigna's reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility, the external review shall be completed within 72 hours.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: availability, upon request, of the diagnosis and treatment codes, and their meanings including, if applicable, the date of service, provider and claim amount; diagnosis and treatment codes, and their meanings; the specific reason or reasons for the adverse determination including, if applicable, the denial code and its meaning and a description of any standard that was used in the denial; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a), if applicable; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of an adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record or other information which: was relied upon in making the benefit determination; was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the appeal processes. However, no action may be brought at all unless brought within three years after a claim is submitted for In-Network services.

HC-FED122 01-25

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a “qualifying event” that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan’s coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct; or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or

- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will

continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;

- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Moving Out of Employer's Service Area or Elimination of a Service Area

If you and/or your Dependents move out of the Employer's service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to emergency services only. Because the Plan does not provide out-of-network coverage, nonemergency services will not be covered under the plan outside of the Employer's service area. If the Employer offers another benefit option through Cigna or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

Employer's Notification Requirements

Your Employer is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  - in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled “Disability Extension” for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer’s Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under “Termination of COBRA Continuation” above.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

HC-FED66 07-14

ERISA Required Information

The name of the Plan is:

Consolidated Welfare Plan

The name, address, ZIP code and business telephone number of the sponsor of the Plan is:

[redacted]

Employer Identification Number (EIN):

[redacted]

Plan Number:

501

The name, address, ZIP code and business telephone number of the Plan Administrator is:

Employer named above

The name, address and ZIP code of the person designated as agent for service of legal process is:

Employer named above

The office designated to consider the appeal of denied claims is:

The Cigna Claim Office responsible for this Plan

The cost of the Plan is shared by Employee and Employer.

The Plan's fiscal year ends on 07/31.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

Plan Trustees

A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

Discretionary Authority

The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to you or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the date you leave Active Service (or later as explained in the Termination Section;)
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

Statement of Rights

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the documents governing the Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities

under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HC-FED72 05-15

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work as determined by your Employer on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

HC-DFS1095 12-17

Ambulance

Licensed ambulance transportation services involve the use of specially designed and equipped vehicles for transporting ill or injured patients. It includes ground, air, or sea transportation when Medically Necessary and clinically appropriate.

HC-DFS1480 01-21

Biologic

A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein (except any chemically synthesized polypeptide), or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), used for the prevention, treatment, or cure of a disease or condition of human beings, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

HC-DFS840 10-16

Biosimilar

A Biologic that is highly similar to the reference Biologic product notwithstanding minor differences in clinically inactive components, and has no clinically meaningful differences from the reference Biologic in terms of its safety, purity, and potency, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

HC-DFS841 10-16

Business Decision Team

A committee comprised of voting and non-voting representatives across various Cigna business units such as clinical, medical and business leadership that is duly authorized by Cigna to effect changes regarding coverage treatment of Medical Pharmaceuticals based on clinical findings provided by the P&T Committee, including, but not limited to, changes regarding tier placement and application of utilization management to Medical Pharmaceuticals.

HC-DFS1494 07-20

Charges

The term charges means the actual billed charges; except when Cigna has contracted directly or indirectly for a different amount including where Cigna has directly or indirectly contracted with an entity to arrange for the provision of services and/or supplies through contracts with providers of such services and/or supplies.

HC-DFS1193 01-19

Chiropractic Care

The term Chiropractic Care means the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

HC-DFS1717 01-22

Cigna Care Network

The term Cigna Care Network refers to a designation given to Participating Providers who meet independently-established criteria determining efficiency and quality.

HC-RDR4 04-10
HC-DFS371

Cigna LifeSOURCE Transplant Network®

The Cigna LifeSOURCE Transplant Network® consists of designated In-Network facilities that have met quality and cost criteria and have contracted with Cigna LifeSOURCE to provide transplant services as a Participating Provider in the Cigna LifeSOURCE Transplant Network®. In order to be considered a facility in the Cigna LifeSOURCE Transplant Network®, the facility must be a designated program for the specific type of transplant requested.

HC-DFS1888 01-24

Convenience Care Clinics

Convenience Care Clinics are staffed by nurse practitioners and physician assistants and offer customers convenient, professional walk-in care for common ailments and routine services. Convenience Care Clinics have extended hours and are located in or near easy-to-access, popular locations (pharmacies, grocery and free-standing locations) with or without appointment.

HC-DFS1629 07-21

Custodial Services

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be self-administered; and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

HC-DFS1894 01-24

Dependent

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is
  - less than 26 years old.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

    Proof of the child's condition and dependence may be required to be submitted to the plan within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, the plan may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild or a child for whom you are the legal guardian. If your Domestic Partner has a child, that child will also be included as a Dependent.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent or Dependent spouse unless the Dependent or Dependent spouse declines Employee coverage. A child under age 26 may be covered as either an Employee or as a Dependent child. You cannot be covered as an Employee while also covered as a Dependent of an Employee.

No one may be considered as a Dependent of more than one Employee.

HC-DFS1718 01-22

Domestic Partner

A Domestic Partner is defined as a person of the same or opposite sex who:

- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by Cigna to be sufficient to establish financial interdependency under the circumstances of your particular case;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit attesting to the above which can be made available to Cigna upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration.

The section of this certificate entitled "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents.

HC-DFS47 04-10
V1

Emergency Medical Condition

Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

HC-DFS1766 01-23

Emergency Services

Emergency Services means, with respect to an Emergency Medical Condition:

- a medical screening examination that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency facility, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition.
- such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or emergency department, as are required to Stabilize the patient (regardless of the Hospital department in which further examination or treatment is provided).
- after the patient is Stabilized, services rendered by an Out-of-Network provider, Hospital or facility (regardless of the Hospital department that provides the services) as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services are provided.

However, such post-Stabilization services are not considered Emergency Services if the attending provider determines the patient is able to travel using non-medical or non-emergency transportation to an available In-Network location within reasonable travel distance and applicable state and federal notice and consent requirements are met.

HC-DFS1905 01-25

Employee

The term Employee means an Employee as determined by your Employer who is currently in Active Service.

HC-DFS1094 12-17

Employer

The term Employer means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf Cigna is providing claim administration services.

HC-DFS1615 01-22

Essential Health Benefits

Essential health benefits means, to the extent covered under the plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

HC-DFS411 01-11

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

HC-DFS10 04-10
V1

Free-Standing Surgical Facility

The term Free-Standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

A Free-Standing Surgical Facility, unless specifically noted otherwise, is covered with the same cost share as an Outpatient Facility.

HC-DFS1484 01-21

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

HC-DFS51 04-10
V1

Hospice Care Services

The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility,

or any other licensed facility or agency under a Hospice Care Program.

HC-DFS52 04-10
V1

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by Cigna; and
- fulfills any licensing requirements of the state or locality in which it operates.

HC-DFS53 04-10
V1

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: specializes in treatment of Mental Health and Substance Use Disorder or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital does not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

HC-DFS1485 01-21

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Use Disorder Services in a Mental Health or Substance Use Disorder Residential Treatment Center.

HC-DFS807 12-15

Injury

The term Injury means an accidental bodily injury.

HC-DFS12 04-10
V1

Maintenance Treatment

The term Maintenance Treatment means:

- treatment rendered to keep or maintain the patient's current status.

HC-DFS56 04-10
V1

Maximum Reimbursable Charge – Medical

See The Medical Schedule for information about Out-of-Network Charges for Certain Services, Out-of-Network Emergency Services Charges, and Out-of-Network Air Ambulance Services Charges.

The Maximum Reimbursable Charge (also referred to as MRC) is the maximum amount that your plan will pay a health care provider for a Covered Expense. Your applicable Copayment, Coinsurance and/or Deductible amount(s), if any, set forth in The Schedule are determined based on the MRC. Unless prohibited by applicable law or agreement, providers may also bill you for the difference between the MRC and their charges, and you may be financially responsible for that amount. If you receive a bill from a provider for more than the What I Owe amount on the Explanation of Benefits (EOB), please call Cigna at the phone number on your ID card.

If a provider is willing to agree to a rate that Cigna, in its discretion, determines to be market competitive, then that rate will become the MRC used to calculate the allowable amount for a Covered Expense. A provider can agree to a rate by: (i) entering into an agreement with Cigna or one of Cigna's third-party vendors that establishes the rate the provider is willing to accept as payment for the Covered Expense; or (ii) receiving a payment from Cigna based on an allowed amount that Cigna or one of Cigna's third-party vendors has determined is a market competitive rate without billing you and/or obligating you to pay the difference between the payment amount and the charged amount.

If a provider does not agree to a market competitive rate as described in the previous paragraph, then the MRC for Open Access Plus In-Network will be based on an amount required by law, or if no amount is required by law, then the lesser of:

- the providers normal charge for a similar service or supply; or
- the percentage of a fee schedule Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable reimbursement for the same or similar service or supply within the geographic market. In the event that Medicare does not have a published rate for a particular service or supply, Cigna may, in its discretion, determine the MRC based on a rate for the same or similar service or supply by applying a Medicare-based methodology that Cigna deems appropriate.

The percentage used to determine the Maximum Reimbursable Charge can be obtained by contacting Member Services/Customer Service.

The Maximum Reimbursable Charge is subject to all other benefit limitations and exclusions and Cigna's applicable Coverage Policies, Reimbursement Policies, and other coding and payment methodologies. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

Note: Some providers attempt to forgive, waive, or not collect the cost share obligation (e.g., your Copayment, Coinsurance and/or Deductible amount(s), if any), that this plan requires you to pay. This practice jeopardizes your coverage under this plan. Please read the Exclusions, Expenses Not Covered and General Limitations section, or call Cigna at the phone number on your ID card for more details.

HC-DFS1853 01-24

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

HC-DFS16 04-10
V1

Medical Pharmaceutical

An FDA-approved prescription pharmaceutical product, including a Specialty Prescription Drug Product, typically required to be administered in connection with a covered service by a Physician or Other Health Professional within the scope of the provider's license. This definition includes certain pharmaceutical products whose administration may initially or typically require Physician or Other Health Professional oversight but may be self-administered under certain conditions specified in the product's FDA labeling.

HC-DFS1632 01-22

Medically Necessary/Medical Necessity

Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:

- required to diagnose or treat an illness, Injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or Other Health Professional;
- not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and

- rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.

In determining whether health care services, supplies, or medications are Medically Necessary, the Medical Director relies on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

HC-DFS1896 01-25

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

HC-DFS17 04-10
V1

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Room and Board, made by a Hospital for medical services and supplies actually used during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

HC-DFS1488 01-21

New Prescription Drug Product

A Prescription Drug Product, or new use or dosage form of a previously FDA-approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or newly-approved use or dosage form becomes available on the market following approval by the U.S. Food and Drug Administration (FDA) and ending on the date Cigna makes a Prescription Drug List coverage status decision.

HC-DFS1498 07-20

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

HC-DFS22 04-10
V1

Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or Hospice Facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities.

HC-DFS1489 01-21

Other Health Professional

The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

HC-DFS1490 01-21

Participating Provider

The term Participating Provider means a person or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services and/or supplies, the Charges for which are Covered Expenses. It includes an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies, the Charges for which are Covered Expenses.

HC-DFS1194 01-19

Patient Protection and Affordable Care Act of 2010 ("PPACA")

Patient Protection and Affordable Care Act of 2010 means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

HC-DFS412 01-11

Pharmacy & Therapeutics (P&T) Committee

A committee comprised of physicians and an independent pharmacist that represent a range of clinical specialties. The committee regularly reviews Medical Pharmaceuticals for safety and efficacy, the findings of which clinical reviews inform coverage determinations made by the Business Decision Team. The P&T Committee's review may be based on consideration of, without limitation, U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

HC-DFS1495 07-20

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

HC-DFS25 04-10
V1

Prescription Drug List

A list that categorizes Prescription Drug Products covered under the plan's Prescription Drug Benefits. This list is developed by Cigna based on clinical factors communicated by the P&T Committee and adopted by your Employer as part of the plan. The list is subject to periodic review and change, and is subject to the limitations and exclusions of the plan.

HC-DFS1775 01-23

Prescription Drug Product

A drug, Biologic (including a Biosimilar), or other product that has been approved by the U.S. Food and Drug Administration (FDA), certain products approved under the Drug Efficacy Study Implementation review, or products marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. For the purpose of benefits under the plan, this definition may also include products in the following categories if specifically identified in the Prescription Drug List:

- Certain durable products and supplies that support drug therapy;
- Certain diagnostic testing and screening services that support drug therapy;
- Certain medication consultation and other medication administration services that support drug therapy; and
- Certain digital products, applications, electronic devices, software and cloud based service solutions used to predict,

detect and monitor health conditions in support of drug therapy.

HC-DFS1633 01-22

Prescription Order or Refill

The lawful directive to dispense a Prescription Drug Product issued by a Physician whose scope of practice permits issuing such a directive.

HC-DFS856 10-16

Preventive Treatment

The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

HC-DFS57 04-10
V1

Primary Care Physician

The term Primary Care Physician means a Physician who qualifies as a Participating Provider in general practice, internal medicine, family practice OB/GYN or pediatrics; and who has been voluntarily selected by you and is contracted as a Primary Care Physician with, as authorized by Cigna, to provide or arrange for medical care for you or any of your insured Dependents.

HC-DFS40 04-10
V1

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a Psychologist.

HC-DFS26 04-10
V1

Review Organization

The term Review Organization refers to an affiliate of Cigna or another entity to which Cigna has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance use disorder professionals, and other trained staff members who perform utilization review services.

HC-DFS808 12-15

Room and Board

The term Room and Board includes all charges made by a Hospital for room and meals and for all general services and activities needed for the care of registered bed patients.

HC-DFS1481 01-21

Sickness – For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

HC-DFS50 04-10
V1

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

HC-DFS31 04-10
V1

Specialist

The term Specialist means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

HC-DFS33 04-10
V1

Specialty Prescription Drug Product

A Medical Pharmaceutical considered by Cigna to be a Specialty Prescription Drug Product based on consideration of the following factors, subject to applicable law: whether the Medical Pharmaceutical is prescribed and used for the treatment of a complex, chronic or rare condition; whether the Medical Pharmaceutical has a high acquisition cost; and, whether the Medical Pharmaceutical is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Prescription Drug Product may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a Medical Pharmaceutical will be considered a Specialty Prescription Drug Product. Specialty Prescription Drug Products may vary by plan benefit assignment based on factors such as method or site of clinical administration, or utilization management requirements based on factors such as acquisition cost. You may determine whether a medication is a Specialty Prescription Drug Product through the website shown on your ID card or by calling member services at the telephone number on your ID card.

HC-DFS858 10-16

Stabilize

Stabilize means, with respect to an Emergency Medical Condition, to provide medical treatment as necessary to assure that no material deterioration of the condition is likely if the individual is transferred from a facility, or, with respect to a pregnant woman who is having contractions, to deliver.

HC-DFS1768 01-23

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

HC-DFS54 04-10
V1

Therapeutic Alternative

A Medical Pharmaceutical that is of the same therapeutic or pharmacological class, and usually can be expected to have similar outcomes and adverse reaction profiles when administered in therapeutically equivalent doses as, another Medical Pharmaceutical or over-the-counter medication.

HC-DFS859 10-16

Therapeutic Equivalent

A Medical Pharmaceutical that is a pharmaceutical equivalent to another Medical Pharmaceutical or over-the-counter medication.

HC-DFS860 10-16

Tiered Benefits

This plan includes tiered benefits for certain covered services identified in The Schedule rendered by Participating

Providers. Under tiered benefits, you pay a lower Copayment or Coinsurance level for certain covered services rendered by Tier 1-identified Participating Providers than if you receive the same covered services from a Participating Provider that is not identified by Cigna as a Tier 1 Participating Provider.

Cigna identifies Participating Providers as "Tier 1" based on consideration of criteria used to measure cost-efficiency and quality and consideration of other factors, including, but not limited to, local market need.

Refer to The Schedule to identify the covered services that are subject to tiered benefits. In order to receive a higher level of In-Network benefits for covered services identified in The Schedule as subject to a tiered benefit, you should also verify that your Primary Care Physician or, as applicable, Specialist has been designated by Cigna as a Tier 1 Participating Provider. Participating Provider tier designations are assessed and may change annually. You can access a list of all Participating Providers by visiting www.cigna.com; or mycigna.com; or by calling the toll-free telephone number on your ID card. Tier 1 Participating Providers are specifically identified in this listing.

HC-DFS1197 01-19

Urgent Care

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

HC-DFS34 04-10
V1

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

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Cigna.

Printed on recycled paper.

EXHIBIT B

Cigna Health and Life Insurance Company
VISALIA CLAIM OFFICE
P.O. BOX 182223
CHATTANOOGA TN 37422-7223

Cigna Health and Life Insurance Company AS AGENT FOR [redacted]

To see the latest claims and plan information on myCigna, scan the code.

[redacted]

DANIEL T KREUTZMANN
[redacted]

Service date
May 1, 2025

Claim # / ID
[redacted]

THIS IS NOT A BILL.
Your health care professional may bill you directly for any amount that you owe.

Provider Network Status:
OUT OF NETWORK

Account name / Account #
[redacted]

Administrative Service Only ERISA

Explanation of benefits

for a claim received for DANIEL T KREUTZMANN, Claim # [redacted]

Patient's relationship to Subscriber: SUBSCRIBER

Subscriber Name: DANIEL T KREUTZMANN

Summary of a claim for services on May 1, 2025

for services provided by AMER MED RESPONSE AMB SV

Amount Billed	$3,644.91	This was the amount that was billed for your visit on 05/01/2025.
Cost Reduction	$3,258.14	**You saved $3,258.14.** CIGNA negotiates discounts with health care professionals and facilities to help you save money.
What your plan paid	$386.77	Your plan paid $386.77 to AMER MED RESPONSE AMB SV.
What I owe	**$0.00**	This is the amount you owe after your discount, your plan paid, and what your accounts paid. People usually owe because they may have a deductible, have to pay a percentage of the covered amount, or for care not covered by their plan. Any amount you paid since care was received may reduce the amount you owe.
You saved	**100%**	You saved $3,644.91 (or 100%) off the total amount billed. This is a total of your discount and what your plan paid. To maximize your savings, visit www.myCIGNA.com or call customer service to estimate treatment costs, or to compare cost and quality of in-network health care professionals and facilities

PLEASE SEE CLAIM DETAILS ON PAGE 3.

Glossary

% Paid: The part of the Amount Billed that your health plan paid
Administrative Service Only ERISA: The Employee Retirement Income Security Act of 1974 (ERISA) sets standards for private sector retirement and health plans. ERISA governs most Administrative Services Only (ASO) plans.
Allowed Amount: The amount that Cigna determines is reasonable reimbursement for covered services provided to you. This may be established in accordance with an agreement between a health care provider and Cigna.
Amount Billed: The amount a health care provider can bill for covered services
Amount Not Covered: The part of the Amount Billed that is not covered by, or eligible for payment under, your plan
Coinsurance: A shared cost between you and your health plan that equals the Allowed Amount for a covered service. This shared cost starts once you have met your deductible.
Copay: A dollar amount you pay for an eligible health care or related service, typically due at the time the service is provided. When present, a copay is usually applied on a per occurrence, per admission, per day, or annual basis.
Cost Reduction: The billed charges were lowered by this amount. Your plan does not pay this amount. You do not have to pay this amount.
Deductible: A set amount you pay out of pocket in one plan or contract year for covered services before your health plan will start covering part of the cost
Discount: The amount you save by using a network health care provider. Cigna negotiates lower rates with network health care providers to help you save money. Using out-of-network providers will cost you more. If you go out-of-network for services, Cigna may be able to get you discounts through third-party vendor contracts.
In-Network: A group of health care providers that have a contract with Cigna to provide you with health care coverage. Using in-network providers will save you money.
Out-of-Network: Any health care provider that does not have a contract with Cigna to provide you with health care coverage. Using out-of-network providers will cost you more money.
Out-of-Pocket Maximum: The total dollar amount a customer will pay toward the coverage of a health plan's benefits/services within a calendar or contract year.
What My Plan Paid: The part of the Amount Billed that your health plan paid
What I Owe: The part of the Amount Billed you are responsible for. This amount might include your deductible, coinsurance, any amount over the maximum reimbursable charge, or products or services not covered by your plan.

Federal Rights of review and appeal

If you have any questions about this explanation of benefits, please call Customer Service at the toll-free number on the front of this form.

If you're not satisfied with this decision, you can start the Appeal process by sending a written request to the address listed in your plan materials within 180 days of receipt of this explanation of benefits (unless a longer time frame is provided by applicable state law or permitted by your plan).
Please follow the steps below to make sure that your appeal is processed in a timely manner.

- Send a copy of this explanation of benefits along with any relevant additional information (e.g. benefit documents, medical records) that helps to determine if your claim is covered under the plan. Contact Customer Service if you need help or have further questions.
- Be sure to include: 1) Your name 2) Account number from the front of this form 3) ID number from the front of this form 4) Name of the patient and relationship and 5) "Attention: Appeals Unit" on all supporting documents.
- Contact Customer Service at the number on the front of this form to request access to and copies of all documents, records and other information about your claim, free of charge.
- You will be notified of the final decision in a timely manner, as described in your plan materials. If your plan is governed by ERISA, you may also bring legal action under section 502(a) of ERISA following our review and decision.
- If, after all required reviews of your claim have been completed, all or part of your claim is denied, you have the right to file a civil action under section 502(a) of the Employee Retirement Income Security Act. Any civil action must be brought in the United States District Court for the Western District of Tennessee within one (1) year after the final plan decision on your claim.

Need Help?

Login or register for myCigna.com to view claim details or chat with a representative. You can call us at (800) 244-6224 (1.800.CIGNA24) or the number on the back of your ID Card. Please have your claim number ready.

cigna healthcare

Claim received for DANIEL T KREUTZMANN
Claim # [redacted]
ID [redacted]

THIS IS NOT A BILL

Claim detail

CIGNA received this claim on May 15, 2025 and processed it on June 14, 2025.

Service dates	Type of service	Amount billed	Cost Reduction	Amount not covered	Allowed amount	Copay	Deductible	What your plan paid	% paid	Coinsurance*	See notes
AMER MED RESPONSE AMB SV, Claim # 9672513693567											
05/01/25	AMBULANCE	3,551.08	3,176.10	0.00	374.98	0.00	0.00	374.98	100	0.00	A0
05/01/25	AMBULANCE	93.83	82.04	0.00	11.79	0.00	0.00	11.79	100	0.00	A0
Total		**$3,644.91**	**$3,258.14**	**$0.00**	**$386.77**	**$0.00**	**$0.00**	**$386.77**		**$0.00**	

** After you have met your deductible, the costs of covered expenses are shared by you and your health plan. The percentage of covered expenses you are responsible for is called coinsurance.*

What I need to know for my next claim

You've met a total of $24,955.55 toward your Unlimited all medical benefits individual lifetime maximum
You've met a total of $1,930.20 toward your $6,000 in network family out of pocket expenses for the policy year beginning 08/01/2024

Other important information that I need to know

IF YOU ARE COVERED BY MORE THAN ONE HEALTH BENEFIT PLAN, YOU SHOULD FILE ALL YOUR CLAIMS WITH EACH PLAN.

Notes

A0 - PROVIDER THIS IS THE ZELIS ERS ALLOWED AMOUNT OFFERED, DIRECT INQUIRIES TO 888.346.8488. MEMBER YOU MAY OWE MORE IF OFFER IS NOT ACCEPTED.

cigna healthcare

Claim received for DANIEL T KREUTZMANN
Claim # 9672513693567
ID U33753706

THIS IS NOT A BILL

Additional information related to the Patient Protection and Affordable Care Act of 2010

If you would like to request information about the specific diagnosis and treatment codes submitted by your Health Care Professional, You can contact your provider directly or you can print and fill out the request form and send it back to Cigna. Go to Cigna.com and click "Find a Form" at the bottom of the page. Choose "Privacy Forms," then "Cigna Health Care Privacy Forms." Print the **Request for Diagnosis and Treatment Code Information form** . If you have difficulty accessing the form, call Customer Service at the toll-free number listed on the back of your Cigna ID card.

If you don't agree with our final internal review of your claim, you may be able to ask for an independent external review. Your plan and any state or federal requirements determine whether your claim is eligible for external review. For questions about your appeal rights or for assistance, call the Employee Benefits Security Administration at 1-866-444-EBSA(3272) or go online to www.askebsa.dol.gov

Your state may also offer a consumer assistance or an Ombudsman program to help you. Go online to mycigna.com, click on the Legal Disclaimer link at the bottom of the page, and select "State Ombudsman/Consumer Assistance Programs" from the drop down menu. If you have difficulty accessing the website, call Customer Service at the toll-free number listed on the back of your Cigna ID card.

If you have difficulty reading English, we offer language assistance. For help please call the Customer Service number on your ID card.

Si tiene problemas para leer el texto en inglés, le ofrecemos asistencia de idiomas. Para obtener ayuda, por favor, llame al número de Servicio al cliente que figura en su tarjeta de identificación.

Si vous avez des difficultés à lire l'anglais, nous offrons une assistance linguistique. Pour toute aide, veuillez composer le numéro du Service à la clientèle qui se trouve sur votre carte d'identification.

Für den Fall, dass Sie den englischen Text nicht verstehen, bieten wir mehrsprachige Unterstützung an. Rufen Sie in diesem Fall bitte die auf Ihrer Versicherungskarte angegebene Kundenservice-Nummer an.

Kung nahihirapan ka sa pagbabasa ng wikang Ingles, nag-aalok kami ng tulong sa wika. Para sa tulong pakitawagan ang numero ng Serbisyo ng Customer sa iyong ID card.

如果對您來說閱讀英文會有困難，我們可以提供您語言協助。欲取得協助，請撥打會員卡上的客戶服務電話號碼。

Bilagáana Bizaad wólta' nił nanitł'ahgo, saad bee niká'a'doowołígíí hóló. Áká'a'áyeed biniiyé t'áá shǫǫdi áká'anídaalwo'go dabinaanishígíí bich'į' hodíílnih éí naaltsoos bee nee hózinígíí bikáa'gi bibéésh bee hane'é yisdzoh.

No Cost Language Services for customers who live in California and customers who live outside of California who are covered under a policy issued in California. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-800-244-6224 for medical/dental or 1-866-421-8629 for mental health/substance use. For more help, call either the HMO Help Center at 1-888-466-2219 or for Non-HMO plans (e.g. PPO) call the CA Dept. of Insurance at 1-800-927-4357. **English**

Servicios de idioma sin costo para asegurados que viven en California y para asegurados que viven fuera de California y que están cubiertos por una póliza emitida en California. Puede obtener un intérprete. Puede hacer que le lean los documentos en español y que le envíen algunos de ellos en ese idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o al 1-800-244-6224 para servicios médicos/dentales de o al 1-866-421-8629 para la salud mental/consumo de sustancias. Para obtener ayuda adicional, llame al Centro de ayuda HMO al 1-888-466-2219 o para los planes que no sean HMO (p. ej. PPO) llame al Departamento de Seguros de CA al 1-800-927-4357. **Spanish**

居住在加州境內的被保人和居住在加州境外但受到加州境內核發保單承保的被保人可取得**免費語言服務**。您可取得口譯員服務。我們可以用中文將文件讀給您聽，並將部分備有中文版的文件寄送給您。欲取得協助，請撥打您會員卡上所列示的電話號碼，或致電 1-800-244-6224 與醫療 / 牙科聯絡，或撥打 1-866-421-8629 聯繫 行為健康服務的精神健康 / 物質使用部門。欲取得其他協助，請致電 1-888-466-2219 與 HMO 協助中心聯絡，或非 HMO 計畫 (例如：PPO) 請致電 1-800-927-4357 與加州保險部聯絡。**Chinese**

خدمات لغوية بدون تكلفة للعملاء المقيمين في ولاية كاليفورنيا والعملاء المقيمين خارج ولاية كاليفورنيا الذين تشملهم سياسة تأمين صادرة في ولاية كاليفورنيا. يُمكنك الاستعانة بمترجم. يمكنك طلب قراءة الوثائق لك وإرسال بعض منها إليك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-800-244-6244 للحصول على الخدمات الطبية / خدمات طب الفم والأسنان أو على الرقم 1-866-421-8629 للصحة النفسية / تعاطي المواد المخدرة. وللحصول على المزيد من المساعدة، اتصل إما بمركز HMO للمساعدة على الرقم 1-888-466-2219 أو للبرامج الأخرى غير HMO (مثل PPO)، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. **Arabic**

캘리포니아 거주 고객 및 캘리포니아에서 발행된 보험으로 보장을 받는 캘리포니아 이외 지역 거주 고객님들을 위한 **무료 언어 지원 서비스**. 귀하는 통역 서비스를 받으실 수 있습니다. 한국어로 서류를 낭독해주는 서비스를 받으실 수 있으며 한국어로 번역된 서류를 받아보실 수도 있습니다. 도움이 필요하신 분은 본인의 ID 카드상에 기재된 안내번호 혹은 의료/치과 안내번호(1-800-244-6224번), 혹은 정신 건강/약물 사용에 대해서는 안내번호(1-866-421-8629번)로 연락해주십시오. 더 많은 도움이 필요하신 분은 HMO 헬프 센터(HMO Help Center), 안내번호 1-888-466-2219번으로 문의하시거나 비-HMO 플랜(예: PPO)에 해당하시는 분은 캘리포니아주 보험국(CA Dept. of Insurance) 안내번호 1-800-927-4357번으로 연락해주십시오. **Korean**

Walang Gastos na Mga Serbisyo sa Wika para sa mga customer na nakatira sa California at mga customer na nakatira sa labas ng California na sakop ng isang polisiyang inisyu sa California. Makakakuha ka ng interpreter. Maaari mong ipabasa para sa iyo ang mga dokumento at maaaring ipadala sa iyo ang ilan sa iyong wika. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-800-244-6224 para sa medikal/dental o sa 1-866-421-8629 para sa mga kalusugang pangkaisipan/paggamit ng droga. Para sa karagdagang tulong, tumawag sa HMO Help Center sa 1-888-466-2219 o para sa mga planong Hindi HMO (hal. PPO) tawagan ang CA Dept. of Insurance sa 1-800-927-4357. **Tagalog**

Dịch vụ trợ giúp ngôn ngữ miễn phí cho khách hàng sinh sống trong tiểu bang California và khách hàng sống ngoài California được đài thọ qua một hợp đồng bảo hiểm y tế ký kết tại California. Quý vị có thể được cấp thông dịch viên. Quý vị có thể được có người đọc văn bản cho quý vị hoặc được nhận tài liệu, văn bản bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên (ID) của quý vị hoặc gọi chương bảo hiểm y tế/nha khoa theo số 1-800-244-6224, hoặc gọi số 1-866-421-8629 để biết thông tin về chương trình chăm sóc sức khỏe tâm thần/sử dụng chất gây nghiện. Để được giúp đỡ thêm, vui lòng gọi Trung tâm Trợ giúp HMO tại 1-888-466-2219 hoặc gọi Bộ Bảo hiểm California tại số 1-800-927-4357 cho các vấn đề thuộc các chương trình bảo hiểm không thuộc loại HMO (như các chương trình PPO). **Vietnamese**

សេវាបកប្រែភាសាដោយឥតអស់ថ្លៃ សម្រាប់អតិថិជនដែលរស់នៅក្នុងរដ្ឋកាលីហ្វ័រនីញ៉ា និងអតិថិជនដែលរស់នៅក្រៅរដ្ឋកាលីហ្វ័រនីញ៉ា ដែលបានគ្រប់គ្រង នៅក្រោមច្បាប់សន្យា បានចេញឱ្យក្នុងរដ្ឋកាលីហ្វ័រនីញ៉ា។ អ្នកអាចទទួលជំនួយពីអ្នកបកប្រែបាន។ អ្នកអាចឱ្យគេអានឯកសារជូនអ្នក និងផ្ញើឯកសារខ្លះ ទៅឱ្យអ្នក ជាភាសាខ្មែរ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខមានកត់នៅលើប័ណ្ណ ID របស់អ្នក ឬលេខ 1-800-244-6224 សម្រាប់ខាងសុខភាព/ធ្មេញ Cigna ឬ 1-866-421-8629 សម្រាប់ខាងឥរិយាបថសុខភាពអារម្មណ៍/ការរំលោភសារធាតុញៀន Cigna។ សម្រាប់ជំនួយថែមទៀត ទូរស័ព្ទទៅមជ្ឈមណ្ឌលជំនួយ HMO តាមលេខ 1-888-466-2219 ឬសម្រាប់គម្រោងមែនមែនជា HMO (ដូចជា PPO) ទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357។**Khmer**

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਉਹਨਾਂ ਗਾਹਕਾਂ ਲਈ ਹਨ ਜੋ ਕੈਲੀਫ਼ੋਰਨੀਆ ਵਿੱਚ ਰਹਿੰਦੇ ਹਨ ਅਤੇ ਉਹਨਾਂ ਗਾਹਕਾਂ ਲਈ ਜੋ ਕੈਲੀਫ਼ੋਰਨੀਆ ਤੋਂ ਬਾਹਰ ਰਹਿੰਦੇ ਹਨ ਅਤੇ ਕੈਲੀਫ਼ੋਰਨੀਆ ਵਿੱਚ ਜਾਰੀ ਕੀਤੀ ਗਈ ਪਾਲਿਸੀ ਦੇ ਅਧੀਨ ਕਵਰਡ ਹਨ। ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਆ ਮਿਲ ਸਕਦਾ ਹੈ। ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ ਅਤੇ ਕੁਝ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ ਸਾਨੂੰ ਆਪਣੇ ਆਈ.ਡੀ. ਕਾਰਡ ਉੱਤੇ ਦਿੱਤੇ ਗਏ ਨੰਬਰ ਤੇ ਜਾਂ ਮੈਡੀਕਲ/ਡੈਂਟਲ ਲਈ 1-800-244-6224 ਤੇ ਜਾਂ ਮਾਨਸਿਕ ਸਿਹਤ/ਪਦਾਰਥਾਂ ਦੇ ਉਪਯੋਗ ਲਈ 1-866-421-8629 ਤੇ ਫੋਨ ਕਰੋ। ਹੋਰ ਮਦਦ ਲਈ, ਜਾਂ ਤਾਂ HMO ਮਦਦ ਕੇਂਦਰ ਨੂੰ 1-888-466-2219 ਤੇ ਫੋਨ ਕਰੋ ਜਾਂ ਗੈਰ HMO ਯੋਜਨਾਵਾਂ (ਉਦਾਹਰਣ ਲਈ PPO) ਲਈ CA ਦੇ ਬੀਮਾ ਵਿਭਾਗ (CA Dept.of Insurance) ਨੂੰ 1-800-927-4357 ਤੇ ਫੋਨ ਕਰੋ। **Punjabi**

خدمات رایگان مربوط به زبان برای مشتریانی که کالیفرنیا زندگی می‌کنند و برای مشتریانی که خارج از کالیفرنیا زندگی می‌کنند اما برنامه‌های بهداشتی صادر شده تحت پوشش هستند. می‌توانید از خدمات یک مترجم شفاهی برخوردار شوید. می‌توانید بگویید مدارک به زبان شما برایتان خوانده شوند و برخی از آن‌ها به زبان شما برایتان ارسال شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسایی شما قید شده است تماس بگیرید و یا با شماره 1-800-244-6224 برای طرح پزشکی/دندانپزشکی یا با شماره 1-866-421-8629 برای برنامه بهداشت روانی/مصرف مواد مخدر تماس بگیرید. برای دریافت کمک بیشتر، با مرکز کمک به HMO شماره 1-866-466-2219 و یا برای طرح‌های غیر HMO (برای مثال PPO) به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. **Persian**

無料の言語サービス。カリフォルニア州にお住まいのお客様、および、カリフォルニア州外にお住まいで、カリフォルニア州において発行された保険のお客様が対象。通訳がご利用でき、書類を日本語でお読みします。また、書類によっては日本語版をお届けできるものもあります。サービスをご希望の方は、IDカードに記載の電話番号、または医療・歯科サービス担当：1-800-244-6224、またはメンタルヘルス・薬物使用のための担当：1-866-421-8629までご連絡ください。その他のお問い合わせは、HMO Help Center：1-888-466-2219、またはNon-HMOプラン（例：PPO「優先医療給付機構」）については、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。**Japanese**

Бесплатные услуги перевода для клиентов, проживающих на территории штата Калифорния, а также для тех клиентов, которые проживают за его пределами и имеют страховой полис, выданный в штате Калифорния. Вы имеете право воспользоваться услугами устного переводчика. Вам могут прочесть ваши документы, а также выслать перевод некоторых из них на вашем языке. Чтобы получить помощь, позвоните нам по номеру, указанному в вашей идентификационной карте; по вопросам получения медицинских/стоматологических услуг, позвоните по номеру 1-800-244-6224, по вопросам психического здоровья/употребления наркотиков — 1-866-421-8629. Для получения дополнительной помощи обращайтесь либо в Центр поддержки HMO по телефону 1-888-466-2219 либо обращайтесь в Министерство страхования штата Калифорния (CA Dept. of Insurance) по телефону 1-800-927-4357 для получения информации в отношении не HMO планов (например PPO). **Russian**

Անվճար Լեզվական Ծառայություններ անդամների համար, ովքեր բնակվում են Կալիֆորնիայում և անդամների համար, ովքեր բնակվում են Կալիֆորնիայից դուրս բայց ապահովագրված են Կալիֆորնիայում տրված ապահովագրությամբ: Դուք կարող եք թարգմանիչ ձեռք բերել: Դուք կարող եք փաստաթղթերը ձեր լեզվով ընթերցել տալ ձեզ համար և նրանց մի մասը ստանալ ձեր լեզվով: Օգնության համար, զանգահարեք մեզ ձեր ինքնության (ID) տոմսի վրա նշված համարով կամ՝ 1-800-244-6244, բժշկական/ատամնաբուժական ծրագրի համար կամ՝ 1-866-421-8629 վարքային առողջապահական ծառայությունների համար՝ հոգեկան առողջության/թմրանյութերի օգտագործման դեպքում: Լրացուցիչ օգնության համար զանգահարեք կա՛մ HMO-ի Օգնության կենտրոն 1-888-466-2219 համարով կամ՝ Ոչ-HMO ծրագրերի համար (օրինակ՝ PPO) զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք 1-800-927-4357 համարով: **Armenian**

Cov Kev Pab Txhais Lus Uas Tsis Tau Them Nqi rau cov qhua uas nyob hauv xeev California thiab cov qhua uas nyob tawm Xeev California uas tau muaj kev pov fwm los ntawm California. Koj yeej muaj tau tus neeg txhais lus. Koj hais tau kom muab cov ntawv nyeem rau koj mloog thiab kom muab qee cov ntaub ntawv txhais ua koj hom lus xa rau. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-800-244-6224 rau chaw pab them nqi kho mob/kho hniav los sis 1-866-421-8629 rau thov kev pab cuam kev noj qab haus huv fab kev coj cwj pwm los ntawm rau kev coj cwj pwm/kev siv yeeb tshuaj. Yog xav tau kev pab ntxiv, hu rau HMO Qhov Chaw Muab Kev Pab ntawm tus xov tooj 1-888-466-2219 los sis rau cov chaw pab them nqi kho mob uas Tsis Koom HMO (piv txwv li yog PPO) hu rau CA Lub Tuam Tsev Tswj Xyuas Txog Kev Tuav Pov Hwm ntawm 1-800-927-4357. **Hmong**

कैलिफ़ोर्निया और कैलिफ़ोर्निया के बाहर रहने वाले कैलिफ़ोर्निया में जारी पॉलिसी के तहत कवर किये गए ग्राहकों के लिए **निःशुल्क भाषा सेवाएं**। आप एक दुभाषिया प्राप्त कर सकते हैं। आप इन दस्तावेज़ों को किसी से पढ़वा सकते हैं और कुछ दस्तावेज़ों को अपनी भाषा में प्राप्त कर सकते हैं। सहायता के लिए, अपने ID कार्ड पर सूचीबद्ध नंबर पर या चिकित्सीय/दंत के लिए 1-800-244-6224 पर या मानसिक स्वास्थ्य/नशे के उपयोग संबंधी सहायता के लिए 1-866-421-8629 पर कॉल करें। अधिक सहायता के लिए, HMO सहायता केंद्र पर 1-888-466-2219 पर कॉल करें या गैर-HMO योजनाओं (उदा. PPO) के लिए 1-800-927-4357 पर CA बीमा विभाग (CA Dept. of Insurance) को कॉल करें। **Hindi**

บริการภาษาโดยไม่เสียค่าใช้จ่าย สำหรับลูกค้าที่อาศัยอยู่ในรัฐแคลิฟอร์เนีย และที่อาศัยอยู่นอกรัฐแคลิฟอร์เนียที่ได้รับการคุ้มครองภายใต้กรมธรรม์ที่ออกในรัฐแคลิฟอร์เนีย คุณสามารถขอล่ามแปลภาษาได้ คุณสามารถขอให้อ่านเอกสารให้คุณฟัง และขอให้ส่งเอกสารบางส่วนถึงคุณเป็นภาษาของคุณ หากต้องการความช่วยเหลือ โปรดโทรศัพท์ถึงเราตามหมายเลขที่ระบุไว้บนบัตรประจำตัวของคุณ หรือหมายเลข 1-800-244-6224 สำหรับบริการของ ด้านการรักษาพยาบาล/ทันตกรรมของ หรือ 1-866-421-8629 สำหรับบริการของ ด้านสุขภาพจิต/การใช้สารที่มีผลต่อจิตประสาทในทางที่ผิ หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรศัพท์ถึงศูนย์ช่วยเหลือสำหรับแผนการรักษาพยาบาลแบบ HMO ที่หมายเลข 1-888-466-2219 หรือสำหรับแผนการรักษาพยาบาลที่ไม่ใช่ HMO (เช่น PPO) โปรดโทรศัพท์ถึง Dept. of Insurance ของรัฐแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 **Thai**

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DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

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Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).

896375b 05/21

EXHIBIT C

Administrative Services Only Agreement

By and Between

[redacted]

"Employer"

And

Cigna Health and Life Insurance Company
"CHLIC"

Effective Date: January 1, 2018

EXCEPT AS PROVIDED BY APPLICABLE LAW, THIS AGREEMENT AND ITS TERMS ARE PROPRIETARY AND CANNOT BE DISCLOSED WITHOUT THE PERMISSION OF EACH OF THE PARTIES

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Client Name: [redacted]
Administrative Services Only Agreement

THIS AGREEMENT, effective January 1, 2018 (the "**Effective Date**") is by and between [redacted] ("**Employer**") and Cigna Health and Life Insurance Company ("**CHLIC**"). Each of Employer and CHLIC may be referred to herein individually as a "**Party**", or collectively as the "**Parties**."

RECITALS:

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

WHEREAS, Employer has requested CHLIC to furnish certain administration services in connection with the Plan (for its own internal purposes, CHLIC identifies Employer's account by the following number [redacted].

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

Definitions

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

Applicable Law means the state, federal and international laws and regulations that apply. Applicable Law includes but is not limited to the Employee Retirement Income Security Act of 1974 ("**ERISA**"), the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), the Foreign Corrupt Practices Act ("**FCPA**") and any other anti-bribery or anti-corruption laws in the countries where the Parties conduct business.

Bank Account means a benefit plan account with a bank designated by CHLIC; established and maintained by Employer in its or a nominee's name. The Bank Account represents a business account of Employer and is not a dedicated account or trust fund for the Plan.

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

Extra-Contractual Benefits means payments which Employer has instructed CHLIC to make for health care services and/or products that CHLIC has determined are not expressly covered under the terms of the Plan, but which are properly payable under the Plan based on the direction of Employer.

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

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

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

Party/Parties means Employer and CHLIC, each a "Party" and collectively, the "Parties".

Plan Benefits means amounts payable under the terms of the Plan for expenses incurred by Members for services/items covered under the Plan.

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

Client Name: [redacted]
Administrative Services Only Agreement

Run-Out Claims means claims for Plan Benefits relating to health care services and products that are incurred but not processed prior to termination of this Agreement; termination of a Plan benefit option or termination of eligible Members, as applicable.

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

Client Name: [redacted]
Administrative Services Only Agreement

Section 1. Term and Termination of Agreement

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

i. The date which is at least sixty (60) days from the date that Employer provides written notice to CHLIC of its intention to terminate this Agreement or at least one hundred and twenty (120) days from the date CHLIC provides written notice to Employer of its intention to terminate this Agreement;

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

iii. The date upon which Employer fails to fund the Bank Account as required by this Agreement provided CHLIC notifies Employer in advance of its election to terminate;

iv. The date upon which Employer fails to pay CHLIC any charges identified in this Agreement when due provided CHLIC notifies Employer in advance of its election to terminate; and

v. The date upon which either party materially breaches this Agreement after providing at least a 30 day period to cure; provided, however, that such cure period shall not apply to any default of Employer relating to its funding obligations under Section 3 or its payment obligations to CHLIC hereunder; and

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

Section 2. Claim Administration and Additional Services

a. While this Agreement is in effect, CHLIC as the party vested with discretionary claim authority shall, consistent with, the claim administration policies and procedures then applicable to its own health care insurance business (i) receive and review claims for Plan Benefits; (ii) determine the Plan Benefits, if any, payable for such claims; (iii) disburse payments of Plan Benefits to claimants; and (iv) provide in the manner and within the time limits required by Applicable Law, notification to claimants of (a) the coverage determination, including in the case of any adverse benefit determination, the specific reasons for the determination, the Plan provisions on which the determination is based and such other information as required under section 503 of ERISA, or (b) any anticipated delay in making a coverage determination beyond the time required by Applicable Law.

b. Following (i) termination of this Agreement, except pursuant to Section 1.iii and 1.iv; (ii) termination of a Plan benefit option or (iii) termination of eligible Members, if any required fees have been paid in full, CHLIC shall process Run-Out Claims for the applicable Run-Out Period (Refer to Schedule of Financial Charges for applicable fees and Run-Out Period). At the termination of any applicable Run-Out Period, CHLIC shall cease processing Run-Out Claims and, subject to the requirements of Section 6.b, make all relevant records in its possession relating to such claims, other than CHLIC's proprietary information, reasonably available to Employer or Employer's designee in its standard reporting format at no additional cost. CHLIC is not required to provide any of its proprietary information to Employer or any other party.

c. Employer hereby delegates to CHLIC the authority, responsibility and discretion to determine coverage under the Plan based on the eligibility and enrollment information provided to CHLIC by Employer. Employer also hereby delegates to CHLIC the authority, responsibility and discretion to (i) make factual determinations and to interpret the provisions of the Plan to make coverage determinations on claims for Plan Benefits, (ii) conduct a full and fair review of each claim which has been denied as defined by ERISA, (iii) decide level one mandatory appeals and level two appeals (if applicable) of "Urgent Care Claims" "Concurrent", "Pre-service" and "Post-service" claims

(as those terms are defined under ERISA) and notify the Member or the Member's authorized representative of its decision within the time and in accordance with the content requirements of ERISA. Employer will ensure that all summary plan description materials provided to Members reflect this delegation of discretionary authority.

d. In addition to the basic claim administrative duties described above, CHLIC shall also perform the Plan-related administrative duties agreed upon by the Parties and specified in Exhibit B. Unless otherwise agreed to in writing by CHLIC, all services identified in this Agreement shall be provided by CHLIC on an exclusive basis with respect to that portion of the Plan administered by CHLIC pursuant to this Agreement.

Section 3. Funding and Payment of Claims

a. Employer shall establish as a part of its general assets a Bank Account, and maintain in the Bank Account an amount sufficient at all times to fund payments from it for the following (collectively "**Bank Account Payments**"): (i) Plan Benefits; (ii) those charges and fees identified in the Schedule of Financial Charges as payable through the Bank Account and (iii) any sales or use taxes, or any similar benefit- or Plan-related charge or assessment however denominated, which may be imposed by any governmental authority. Bank Account Payments may include without limitation: (a) fixed per person payments and pay-for-performance payments to Participating Providers; (b) amounts owed to CHLIC; and (c) amounts paid to CHLIC's affiliates and/or subcontractors for, among other things, network access or in- and out-of network health care services/products provided to Members. CHLIC may credit the Bank Account with payments due Employer under a stop loss policy issued by CHLIC or an affiliate.

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

c. In the event that sufficient funds are not available in the Bank Account to pay all Bank Account Payments when due, CHLIC shall cease to process claims for Plan Benefits including Run-Out Claims. CHLIC will promptly notify Employer of such fund insufficiency.

d. CHLIC will promptly adjust any underpayment of Plan Benefits or pay-for-performance payments by drawing additional funds due the claimant from the Bank Account. In the event CHLIC determines that it has overpaid a claim for Plan Benefits or paid Plan Benefits to the wrong party, it shall take all reasonable steps consistent with the policies and procedures applicable to its own health care insurance business to recover the overpayments of Plan Benefits. CHLIC shall also take all reasonable steps consistent with the policies and procedures applicable to its own health care insurance business to collect pay-for-performance payments due to Employer or to recover pay-for-performance overpayments (collectively "Pay-for-Performance Recoveries"). CHLIC shall not be required to initiate court, mediation, arbitration or other administrative proceedings to recover any overpayment of Plan Benefits or to collect or recover Pay-for-Performance Recovery. However, when it elects to do so, CHLIC is expressly authorized by Employer to take all actions on behalf of the Employer and/or the Plan to pursue overpayment recovery of Plan Benefits or to collect or recover Pay-for-Performance Recovery including, but not limited to, retaining counsel, settling and compromising claims or Pay-for-Performance Recoveries, in which case CHLIC shall be responsible for the attorney fees, court costs or arbitration fees incurred by CHLIC in the specific overpayment recovery action of Plan Benefits (not applicable to subrogation or conditional claim payment recoveries) or to collect or recover Pay-for-Performance Recovery, but not any other associated third party costs absent consent of CHLIC. CHLIC shall not be responsible for reimbursing any unrecovered payments of Plan Benefits or Pay-for-Performance Recoveries unless made as a result of its (i) material breach of the standard of care applicable to similarly situated claims administrators, as provided in Section 7.c hereunder, (ii) gross negligence or (iii) intentional wrongdoing.

Client Name: [redacted]
Administrative Services Only Agreement

e. Employer shall promptly reimburse CHLIC for any Bank Account Payments paid by CHLIC with its own funds on Employer's behalf and no such payment by CHLIC shall be construed as an assumption of any of Employer's liability for such Bank Account Payments.

f. Following termination of this Agreement, Employer shall remain liable for payment of all Plan Benefits and other due Bank Account Payments and for all reimbursements due Members under the Plan.

This Section 3 shall survive termination of this Agreement.

Section 4. Charges

a. Charges. CHLIC shall provide to Employer a monthly statement of all charges Employer is obligated to pay under this Agreement that are not paid as Bank Account Payments. Payment of all billed charges shall be due on the first day of the month, as indicated on the monthly statement. Payments received after the last day of the month in which they are due, shall be subject to late payment charges, from the due date at a rate calculated as follows: the one (1) year Treasury constant maturities rate for the first week ending in January plus five percent (5%). For purposes of calculating late payment charges, payments received will be applied first to the oldest outstanding amount due. CHLIC may reasonably revise the methodology for calculating late payment charges upon thirty (30) days' advance written notice to Employer.

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

c. Retroactive Changes and Terminations. Employer shall remain responsible for all applicable charges and Bank Account Payments incurred or charged as provided in this Section 4 through the date CHLIC processed Employer's notice of a retroactive change or termination of a Member. However, if the change or termination would result in a reduction in charges, CHLIC shall credit to Employer the reduction in charges charged for the shorter of (a) the sixty (60) day period preceding the date CHLIC processes the notice, or (b) the period from the date of the change or termination to the date CHLIC processes the notice.

This Section 4 shall survive termination of this Agreement.

Section 5. Enrollment and Determination of Eligibility

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

b. Release of Liability. Notwithstanding any inconsistent provision of this Agreement to the contrary, if Employer, fails to provide CHLIC with accurate enrollment and eligibility information, benefit design requirements, or other agreed-upon information in CHLIC's standard timeframe and format, CHLIC shall have no liability under this

Agreement for any act or omission by CHLIC, or its employees, affiliates, subcontractors, agents or representatives, directly or indirectly caused by such failure.

c. Reconciliation of Eligibility and Information and Default Terminations. CHLIC will periodically (i.e., typically monthly) share potential discrepancies in eligibility information with Employer. Employer will review and reconcile any discrepancies within thirty (30) days of receipt and provide CHLIC corrected eligibility information. If Employer fails to timely do so, CHLIC may terminate coverage for any Member not listed as eligible in Employer's submitted eligibility information.

Section 6. Claim Audits and Confidentiality

a. Claim Audit. Employer may, audit CHLIC's payment of Plan Benefits in accordance with the following requirements:

i. Employer shall provide to CHLIC a scope of audit letter and the fully executed Claim Audit Agreement, a sample of which is attached hereto as Exhibit C, together with a forty-five (45) day advance written request for audit.

ii. Employer will designate with CHLIC's consent (which consent shall not to be unreasonably withheld) an independent, third-party auditor to conduct the audit (the "**Auditor**").

iii. Employer and CHLIC will agree upon the date for the audit during regular business hours at CHLIC's office(s).

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

v. 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. If significant erroneous claim payments are identified in an audit, the Employer and Connecticut General will further evaluate such errors and mutually determine reasonable and appropriate steps to address such errors, subject to the provisions of Sections 3.c. and 7.c. of this Agreement.

vi. The notice frequency and sample restrictions described in this Section 6 will not apply with respect to any audit required by a court or administrative tribunal or pursuant to a governmental audit and CHLIC will take all reasonable measures to comply with any such audit requests.

vii. Employer shall be responsible for its Auditor's costs.

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

b. Confidentiality

i. Subject to the requirements of Applicable Law, the terms of this Agreement and the Privacy Addendum/Business Associate agreement in Exhibit D between Employer and CHLIC, and a signed Confidentiality Agreement between CHLIC and applicable designee(s). CHLIC shall release copies of confidential claims and Plan Benefit payment information in CHLIC's claims system ("**Confidential Information**") and may release copies of proprietary information relating to the Plan in CHLIC's claims system ("**Proprietary Information**") to the Employer and/or its designee(s). Employer agrees that Employer and its designee(s) will keep Confidential Information and Proprietary Information confidential and will use Confidential Information and Proprietary Information solely for the purpose of administering the Plan or as otherwise required by law. Employer is solely responsible for the consequences of any use, misuse, or disclosure of Confidential Information by Employer or its designee(s) provided by CHLIC pursuant to this paragraph b.

ii. CHLIC will maintain the confidentiality of all Protected Health Information in its possession in accordance with the Privacy Addendum/Business Associate Agreement in Exhibit D 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.

c. Upon termination of this Agreement and subject to the provisions of Section 6.b above, CHLIC shall make information available, to the extent administratively feasible, in its standard format at no additional charge. Requests for any such information in a non-standard format will be subject to additional fees to be paid by Employer as agreed to by the Parties.

The obligations set forth in this Section 6 (b), shall survive termination of this Agreement.

Section 7. Plan Benefit Liability

a. Employer Liability for Plan Benefits. Employer is solely responsible for all Plan Benefits including any Plan Benefits paid as a result of any legal action. Subject to Employer's payment of the fee described in Section 7. e, CHLIC will undertake the defense of any action arising out of the administration, processing or determination of benefit claims so long as CHLIC processed the claim. If Employer is also named as a party, CHLIC will defend Employer provided that there is no conflict of interest between CHLIC and Employer. Subject to Section 7.c., Employer is responsible for reimbursing CHLIC, its directors, officers and employees for any reasonable expense incurred (including reasonable attorneys' fees) by them in the defense of any action or proceeding involving a claim for Plan Benefits. Employer agrees to pay and is liable for the full amount of Plan Benefits included in any judgement or settlement of such action. Each Party shall reasonably cooperate with the other, in its defense of such actions.

If Employer directs CHLIC in writing to pay Extra-Contractual Benefits, Employer is responsible for funding the payment and such payments shall not be considered in determining reimbursements or payments under stop loss insurance provided by CHLIC or CHLIC affiliate except as otherwise specifically provided by such policy or in determining any CHLIC or CHLIC affiliate risk-sharing or performance guarantee reimbursements. Employer shall reimburse CHLIC for any liability or reasonable expenses (including reasonable attorneys' fees) CHLIC may incur in connection with making such payments.

b. Employer Liability for Plan-Related Expenses. Employer shall reimburse CHLIC for any amounts CHLIC may be required to pay (i) as state premium tax or any similar Plan-related tax, charge, surcharge or assessment, or (ii) under any unclaimed or abandoned property, or escheat law, with respect to Plan Benefits and any penalties and/or interest thereon. CHLIC will be responsible for all taxes, charges, surcharges or assessments imposed on it with respect to its business as a claims administrator.

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

d. Subject to payment of the fee in Section 7.e., CHLIC shall defend against any legal action or proceeding brought against CHLIC to recover a claim for benefits under the Plan as administered by CHLIC. If a demand for benefits under the Plan is asserted, or litigation, investigation or other proceedings are commenced against CHLIC by a Member, or by any other party on behalf of a Member, in connection with the Plan, CHLIC shall provide notice to the Employer as soon as practicable, depending upon the circumstances of the dispute involved. CHLIC's delay in providing any notice under this section will not be a breach unless the delay has substantially prejudiced the Plan's rights as it relates to the legal action or proceeding in question. CHLIC will select and retain counsel and will assume liability for the payment of legal fees, costs and disbursements in connection with the adjudication of the dispute. If the Employer or Plan are also named in the legal action or proceeding, Employer reserves the right to retain separate counsel for itself and the Plan, in its sole discretion and at its own expense. If during such litigation, investigation or proceedings Employer and CHLIC are both represented by the same counsel selected by CHLIC and a conflict of interest arises, the Employer shall waive any conflict for such representation and retain its own counsel, or separate counsel for the Plan, at its own expense. Each Party will provide the other with reasonable cooperation in the defense of any such matter. CHLIC is authorized to settle or compromise any claim to recover benefits under the Plan arising out of a course of legal action with the approval of Employer, which approval shall not be unreasonably withheld.

e. Prior to the beginning of each Plan Year, and contingent upon timely payment by Employer of the associated additional "Claim Litigation Charge" set forth in the Schedule of Financial Charges, Employer may elect to have CHLIC assume responsibility for the management of any claim-related legal action and bear the legal expenses associated with defending such action so long as CHLIC processed the claim(s) in dispute. This option does not extend to actions against Employer and/or CHLIC related to the payment of Extra-Contractual Benefits. Each Party will provide notice to the other of any action and will fully cooperate in the defense of the action unless a potential conflict of interest exists. Employer shall be liable to pay Plan Benefits awarded or paid by settlement, judgment or otherwise.

f. In the event of any legal action or proceeding against the Employer or Plan pertaining to the scope or nature of Covered Services described in the Plan, CHLIC shall make available to Employer, the Plan, and their respective counsel, such evidence that is not privileged or otherwise confidential and is relevant to such action or proceeding.

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

Section 8. Modification of Plan and Charges

a. Except as may be otherwise provided in the Schedule of Financial Charges, CHLIC shall have the right to revise the charges identified in this Agreement (i) on the first anniversary of this Agreement and at any time thereafter by giving Employer at least ninety (90) days' prior written notice, but not more frequently than once in a twelve (12) month period, (ii) upon any material modification or amendment of the benefits under the Plan, (iii) upon any variation of twenty five percent (25%) or more in the number of Members used by CHLIC to calculate its charges under this Agreement, and/or (iv) upon any change in law or regulation that materially impacts CHLIC's liabilities and/or responsibilities under this Agreement.

b. Except when precluded due to retroactive charges in the law, Employer shall provide CHLIC written notice of any modification or amendment to the Plan sufficiently in advance of any such change as to allow CHLIC to implement the modification or amendment. Employer and CHLIC shall agree upon the manner and timing of the implementation of such modification or amendment subject to CHLIC's system and operational capabilities and the requirements of applicable law.

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

Section 9. Modification of Agreement

This Agreement and the associated Exhibits constitute the entire contract between the Parties regarding the subject matter herein. Except, as otherwise provided herein, the provisions of this Agreement shall control in the event of a conflict with the terms of any other agreements. Except for changes to the charges identified in this Agreement, no modification or amendment hereto shall be valid unless in writing and agreed to by an authorized person of each of the Parties. The charges identified in this Agreement may be revised in accordance with Section 8 by CHLIC providing written notice to Employer pursuant to Section 19 and Employer indicating its acceptance of the modification in writing within thirty (30) days of receipt of such notice from CHLIC. The revised charges will be effective on the date indicated in CHLIC's written notice to Employer unless otherwise agreed to by CHLIC and Employer.

Section 10. Laws Governing Agreement

a. This Agreement shall be construed in accordance with the laws of the State of Texas without regard to conflict of law rules, and both Employer and CHLIC consent to the venue and jurisdiction of its courts. Venue shall be in Dallas County, Texas

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

Section 11. Information in CHLIC Processing Systems

CHLIC may retain and use all Plan-related claim/payment information recorded/integrated into CHLIC's business records (including claim processing systems) in the ordinary course of business. Such information will be available to

Employer pursuant to Section 6. CHLIC will retain such Plan-related claim/payment information in accordance with its record retention policy, the Privacy Addendum/Business Associate Agreement in Exhibit D and Applicable Law.

Section 12. Resolution of Disputes

It is understood and agreed that any dispute between the Parties arising from or relating to the performance or interpretation of this Agreement ("**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 initiate Executive Review by giving the other Party written notice of the Controversy and shall specifically request Executive Review of said Controversy in such notice. Within twenty (20) calendar days of any Party's written request for Executive Review, the receiving Party shall submit a written response. Both the notice and response shall include a statement of each Party's position and a summary of the evidence and arguments supporting its position. Within thirty (30) calendar days of any Party's request for Executive Review, an executive level employee of each Party shall be designated by the Party to meet and confer with his/her counterpart to attempt to resolve the dispute. Each representative shall have full authority to resolve the dispute.

b. In the event that a Controversy has not been resolved within thirty-five (35) calendar days of the request of Executive Review under Section 12.a, above, the disputing Party shall initiate mediation by providing written notice to the other Party, which shall be conducted in Dallas, Texas, in accordance with the American Arbitration Association Commercial Mediation Rules ("**Mediation**"). Each Party shall assume its own costs and attorneys' fees, and the compensation and expenses of the mediator and any administrative fees or costs associated with the mediation proceeding shall be borne equally by the Parties. If Mediation is unsuccessful in resolving the dispute, the Parties may pursue any available legal rights.

This Section 12 shall survive termination of this Agreement.

Section 13. Third Party Beneficiaries

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

Section 14. Waivers

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

Section 15. Headings

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

Section 16. Severability

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

Section 17. Force Majeure

Neither Party shall be liable for any failure to meet any of their obligations under this Agreement where such failure to perform is due to any contingency beyond the reasonable control of such party or its affiliates or subcontractors, its employees, officers, or directors. Such contingencies include, but are not limited to, acts of God, fires, wars, accidents, labor disputes or shortages, and governmental actions, laws, ordinances, rules or regulations (a "Force Majeure Event"). If either Party is prevented from, or delayed in performing any of its obligations under this Agreement by a Force Majeure Event, it will promptly notify the other Party by telephone or electronic mail, as soon as reasonably possible under the circumstances, of the inception of the delay and describe, in reasonable detail, the circumstances constituting the Force Majeure Event and of the obligations, the performance of which are thereby delayed or prevented. Such Party will continue to use reasonable efforts to recommence performance as soon as reasonably practicable. This Section shall not excuse the Parties from any liability which results from failure to have in place reasonable disaster recovery and safeguarding plans for protection of data that each party is responsible for maintaining. Notwithstanding the foregoing, this section shall not in any way alter or release the Employer from its obligations under Section 3 and 4 of this Agreement.

Section 18. Assignment and Subcontracting

No Party may assign any right, interest, or obligation hereunder without the express written consent of the other Party; provided, however that CHLIC may assign any right, interest, or responsibility under this Agreement to its affiliates and/or subcontract specific obligations under this Agreement provided that CHLIC shall not be relieved of its obligations under this Agreement when doing so.

Section 19. Notices

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

To CHLIC:
Cigna Health and Life Insurance Company
25500 North Norterra Drive, Building B
Phoenix, AZ 85085
Attention: Brad Anderson, Risk & Underwriting Director

To Employer:
[redacted]

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

Client Name: [redacted]
Administrative Services Only Agreement

Section 20. Identifying Information and Internet Usage

Except, as necessary in the performance of their duties under this Agreement, no Party may use the other's name, logo, service marks, trademarks or other identifying information or to establish a link to the other's World Wide Web site without its prior written approval.

Section 21. Compliance with Federal and/or State Programs

As of the Effective Date of this Agreement, CHLIC does not participate in any federal and/or state reimbursement program as a health care provider. To the extent CHLIC ever begins to participate in any federal and/or state reimbursement program as a health care provider, CHLIC and all employees related to this engagement will not be or have: (i) been listed by any federal or state agency as excluded, debarred, suspended or otherwise ineligible to participate in federal and/or state programs; or (ii) been convicted of any crime relating to any federal and/or state program. CHLIC further agrees to immediately notify Employer in writing in the event CHLIC or any employee related to this engagement is listed by a federal or state agency as excluded, debarred, suspended or otherwise ineligible to participate in other federal and/or state programs or if CHLIC or any employee related to this engagement is convicted of any crime relating to any such program.

Section 22. Compliance with the Deficit Reduction Act

False Claims. CHLIC acknowledges that Employer has provided it with its Code of Ethical Conduct relative to the False Claims Act ("FCA"), 31 U.S.C. §§ 3729-3733. This includes but is not limited to the following: (i) the FCA imposes civil liability on any person or entity that knowingly submits, or causes to be submitted, a false or fraudulent claim for payment to the U.S. government; and (ii) the FCA prohibits knowingly making or using (or causing to be made or used) false records or statements in order to get a false or fraudulent claim paid by the federal government.

Enforcement and Penalties. CHLIC understands that under the FCA, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of $5,500 to $11,000 per false claim. Other possible enforcement actions include suspension of payment, referral to the Office of Inspector General for potential exclusion from the program, or disenrollment.

Reporting. CHLIC understands that information regarding a potential false claims violation under the FC as it relates only to Employer should be reported to Employer's Compliance Officer at [redacted] or anonymously to Employer hotline at [redacted] to the extent CHLIC is aware of such claims.

Qui Tam Actions. Under the FCA, persons may file a "qui tam" or whistle blower lawsuit against an individual or entity on behalf of themselves and the government. The person filing the lawsuit is protected against discharge, demotion, suspension, threats, harassment, and discrimination related to such lawsuit. Acts in violation of these protections may entitle the employee to reinstatement with seniority, double back pay, interest on back pay, compensation for discriminatory treatment, reasonable attorney's fees, and other litigation costs

Client Name: [redacted]
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SIGNATURES

IN WITNESS WHEREOF, the Parties have caused this Agreement, to be executed in duplicate and signed by their respective officers duly authorized to do so as of the dates given below. Employer executes as the authorized representative of the Plan with respect to the Privacy Addendum to this Agreement.

Dated at [redacted]

[redacted]

[redacted]

Duly Authorized

Dated at Hartford, Connecticut

CIGNA HEALTH AND LIFE INSURANCE COMPANY

This 1st day of August, 2018

By: Victoria A. Sirica

Name: Victoria A. Sirica
Its Contractual Agreement Unit Manager
Duly Authorized

ATTORNEYS' EYES ONLY

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Client Name: [redacted]
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Schedule of Financial Charges

Certain fees and charges identified in this Schedule of Financial Charges will be billed to Employer monthly in accordance with CHLIC's then standard billing practices. However, CHLIC is authorized to pay all fees and charges from the Bank Account unless otherwise specified in this Agreement. No rebates are payable with respect to the benefits payable under the Plan so no adjustments will be made to fees or charges payable to CHLIC on that basis.

MEDICAL ADMINISTRATION CHARGES		
Product	**Description**	**Charge**
Medical	• HSA Open Access Plus (OAP) with PHS Plus Medical Management (Non-Cobra)	**$41.25/employee/month**
Medical	• HSA Open Access Plus (OAP) with PHS Plus Medical Management (Cobra)	**$37.16/employee/month**
Medical	• Open Access Plus In-Network (OAPIN) with PHS Plus Medical Management	**$37.16/employee/month**
Medical	• LocalPlus IN (LCPIN) with PHS Plus Medical Management	**$37.16/employee/month**
MEDICAL NETWORK ACCESS FEE, UTILIZATION MANAGEMENT FEE AND OPTIONAL PROGRAM FEE		
Product	**Description**	**Charge**
Medical	• HSA OAP Access Fee (All Plans)	**$24.91/employee/month Included in Medical Administration Charge**
Medical	• OAPIN Access Fee	**$24.91/employee/month Included in Medical Administration Charge**
Medical	• LCPIN Access Fee	**$24.91/employee/month Included in Medical Administration Charge**

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CIGNA CHOICE FUND AND OTHER CONSUMER DIRECTED ACCOUNT ADMINISTRATION SERVICES AND CHARGES		
	Product	**Charge**
	• Cigna Choice Fund Health Savings Account (HSA) Administration (Non-Cobra Only)	**$4.09/employee/month Included in Medical Administration Charge**
Personal Health Team A	A program that encompasses those who are at risk for a health related condition and those who are experiencing health concerns. This program centers on the use of behavioral coaching and case management principles and uses nurses and health coaches. This solution includes the following components: • Pre and post discharge calls when CHLIC is the medical carrier • Inpatient advocacy calls (when permission is obtained from the Member) • Short term and complex case management • Vendor partner referral and integration • Predictive modeling outreach • Coordination with Cigna onsite programs, as appropriate • 24 hour Health Information Line post follow up call outreach • Health Risk Assessment outreach • Multi-session health and wellness coaching • Treatment decision support and coaching • Gaps in care outreach and counseling • Single point of contact for continuity in the advocate/Member relationship Members are identified for participation in the Personal Health Team Program through a variety of sources including but not limited to clinical algorithms developed and implemented by CHLIC, self-enrollment, inpatient admissions, short-term and/or complex case management (medical).	**For HSA OAP: Included in Medical Access Fee**
AMOUNTS OWED TO CHLIC		
Amounts paid by CHLIC with its own funds on behalf of Employer or the Plan with respect to charges for which Employer or the Plan is obligated to pay under this Agreement including Plan Benefits, Bank Account Payments (including fixed per person payments and pay-for-performance payments to Participating Providers), governmental taxes or assessments.		

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CIGNA HOME DELIVERY PHARMACY DISCLOSURE		
	Product	**Charge**
Cigna Home Delivery Pharmacy (a CHLIC affiliated company)	Specialty Drugs dispensed by Cigna Home Delivery Pharmacy and administered under the Plan's medical benefit. Cigna Home Delivery Pharmacy and any other licensed pharmacy affiliate of CHLIC may maintain product purchase discount arrangements and/or fee-for-service arrangements with pharmaceutical manufacturers and wholesale distributors. Cigna Home Delivery Pharmacy or any other licensed pharmacy affiliate of CHLIC contract for these arrangements on its own account in support of its pharmacy operations. These arrangements relate to services provided outside of this Agreement and other pharmacy benefit management arrangements and may be entered into without regard to whether a specific drug is on one of the formularies that CHLIC offers to entities like Employer that sponsor group health plans. Discounts and fee-for-service payments received by Cigna Home Delivery Pharmacy or any other licensed pharmacy affiliate of CHLIC are not part of the administrative fees or other charges paid to CHLIC in connection with CHLIC's services hereunder. This provision shall survive termination or expiration of the Agreement.	**The drug's charge under a national specialty drug discount schedule that generates a 12.5% annual average aggregate discount off AWP across specialty drug claims dispensed at Cigna Home Delivery Pharmacy to CHLIC's self-funded and insured group-client book of business.**
FEES FOR PROCESSING RUN-OUT CLAIMS		
HSA OAP, OAPIN, LCPIN	Run-Out Period of twelve (12) months CHLIC shall not be required to process Run-Out Claims until it has received full payment of the required fees.	**The terminal Fee Administration will be based off of the enrollment for the month preceding termination and will equal $13.50 per month. Will also charge four (4) month of Basic Medical (excludes Access) Administration Fees.**

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

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CHLIC MEDICAL COST CONTAINMENT FEES		
CHLIC administers the following programs to contain costs with respect to charges for health care service/supplies that are covered by the Plan. In administering these programs, CHLIC contracts with vendors to perform program related services. Specific vendor fees are available upon request subject to a mutually agreed upon non-disclosure agreement. CHLIC's charge for administering these programs is the percentage (indicated below) of either (1) the "net savings" (i.e. the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings, less the applicable vendor fee which generally ranges from 7-11% of the program savings) or (2) the "gross savings" (i.e. the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings; CHLIC pays the applicable vendor fee) or (3) the "recovery" (i.e. the amount recovered) as applicable. For charges for covered services received from a non-Participating Provider (including emergency/urgent care services that are covered at the in-network benefit level), CHLIC may apply discounts available under agreements with third parties or through negotiation of the billed charges. These programs are identified below as the Network Savings Program Supplemental Network, and Medical Bill Review (pre-payment). CHLIC charges the percentage shown for administering these programs. Applying these discounts may result in higher payments than if the maximum reimbursable charge is applied. Whereas application of the maximum reimbursable charge may result in the patient being balance billed for the entire unreimbursed amount, applying these discounts avoids balance billing and substantially reduces the patient's out-of pocket cost. If no discount is available or negotiated, reimbursement will be based upon: (i) If charges are not subject to CHLIC's benefit enhancement policy – the plan's maximum reimbursable charge (in which case the patient may be balance billed by the provider if the provider's charge exceeds the plan's maximum reimbursable charge); or (ii) If charges are subject to CHLIC's benefit enhancement policy – depending upon the Employer's election: a. the amount of provider's billed charge not exceeding the greater of a CHLIC determined percentage of the Medicare allowable amount (the 80th percentile of the reasonable and customary charge if there is no Medicare allowable charge) or the amount required by state or federal, law (in the case of emergency room services) for charges subject to CHLIC's benefit enhancement policy (patient may be balance billed by the provider if the provider's charge exceeds such amount), or b. the provider's billed charge. This administration of charges for covered services from non-Participating Providers is consistent with the claim administration practices with respect to CHLIC's own health care insurance business where applicable.		
1.	Network Savings Program	**29% of net savings**
2.	Supplemental Network	**29% of net savings**
3.	Medical Bill Review – (Pre-payment Cost Containment for Non-contracted claims):	
	Inpatient Hospital Bill Review	

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Client Name: [redacted]
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	• Line Item Analysis	**Lesser of 5% of hospital bill or the savings achieved**
	• Professional Fee Negotiation	**29% of net savings**
	Outpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
	Physician/Professional Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
4.	Medical Bill Review – (Pre or Post-payment Cost Containment for Non-contracted and Contracted claims):	
	• Bill Audit	**29% of the savings/recovery achieved plus hospital fees or expenses passed through**
	Diagnosis Related Grouping (DRG) Validation/Audits and Recovery. An overpayment audit and recovery program in which CHLIC or its vendors review paid claim data to identify overpayments based on inaccurate DRG coding.	**29% of recovery plus any fees or expenses passed through by the hospital or regulatory agency**
	Medical Implant Device Audits	**29% of recovery**
5.	COB Vendor Recoveries [Exclusive of pharmacy programs where claims are adjudicated at time prescription is received.]	**29% of recovery**
6.	Secondary Vendor Recovery Program	**29% of recovery**
7.	Provider Credit Balance Recovery Program	**29% of recovery**
8.	High Cost Specialty Pharmaceutical Audits (this service is only provided with respect to Medical coverage)	**29% of recovery**
9.	Class Action Recoveries	**35% of recovery**

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

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	NOTICE REGARDING PAYMENTS FROM THIRD PARTIES	
	CHLIC may receive and retain payments under contracts with pharmaceutical manufacturers with respect to Members' utilization of the manufacturer's specialty drugs covered under the Employer's Plan medical benefit. If CHLIC enters into any such contracts, it does so on its own behalf, and not as agent of the Employer or the Plan. CHLIC contracts with pharmaceutical manufacturers for any such remuneration on its own behalf and for its own benefit, and not on behalf of Employer or the Plan. Accordingly, CHLIC retains all right, title and interest to any and all such remuneration received from manufacturer; neither Employer, its Members, nor Employer's Plan retains any beneficial or proprietary interest in any such remuneration, which shall be considered part of the general assets of CHLIC. This provision shall survive termination or expiration of the Agreement.	**All Medical Products**
	From time to time, CHLIC, directly or through its affiliates, arranges with third parties (e.g., service vendors, provider network managers) to provide various services (e.g., cost-containment services or health care services) in connection with the Plan. CHLIC and its affiliates may receive payments from such third parties to help defray CHLIC's expenses associated with its implementation and/or ongoing administration of these arrangements or as a reimbursement for services provided to such parties by CHLIC. CHLIC may also receive compensation from third-party vendors that Employer may retain based upon a referral from CHLIC or that Members may utilize following an introduction facilitated by CHLIC or an affiliate.	**All Products**
	COMPLIANCE ASSISTANCE	
	CHLIC shall provide the following services to assist Employer in meeting its compliance obligations under section 2715 of the Public Health Service Act as added by the Patient Protection and Affordable Care Act and applicable regulations with respect to the provision of the Summary of Benefits and Coverage ("SBC), translation notice and glossary. Applicable to all medical plans including HRA and FSA which are considered "group health plans" subject to the SBC requirements.	
1.	Preparation of SBC, translation notice. CHLIC will not be responsible for any changes that Employer makes to the SBC.	**No charge**
2.	Provide SBC, translation notices prepared by CHLIC to Employer electronically as well as any updates or material modifications.	**No charge**

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3.	Include in SBC a summary of benefits administered by carve-out vendor if Employer or carve-out vendor provides CHLIC with necessary carve-out benefit information at least twelve (12) weeks prior to the date the SBCs are to be delivered to Employer.	**$500 for each benefit option under the Plan for which carve-out vendor benefits are included in SBC**

ADDITIONAL SERVICES		
Service	**Description**	**Charge**
Behavioral Health	Behavioral Care Advocacy provides behavioral health services in which claims are funded on a fee-for-service basis. It includes focused utilization review and case management for both inpatient and outpatient, in-network behavioral health services. This payment arrangement is with respect to the CA/NC/VI Member population only.	**Included in Medical Access Fee**

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Personal Health Team A	A program that encompasses those who are at risk for a health related condition and those who are experiencing health concerns. This program centers on the use of behavioral coaching and case management principles and uses nurses and health coaches. This solution includes the following components: • Pre and post discharge calls when CHLIC is the medical carrier • Inpatient advocacy calls (when permission is obtained from the Member) • Short term and complex case management • Vendor partner referral and integration • Predictive modeling outreach • Coordination with Cigna onsite programs, as appropriate • 24 hour Health Information Line post follow up call outreach • Health Risk Assessment outreach • Multi-session health and wellness coaching • Treatment decision support and coaching • Gaps in care outreach and counseling • Single point of contact for continuity in the advocate/Member relationship Members are identified for participation in the Personal Health Team Program through a variety of sources including but not limited to clinical algorithms developed and implemented by CHLIC, self-enrollment, inpatient admissions, short-term and/or complex case management (medical).	**For OAPIN and LCPIN Products: Included in Medical Access Fee**
Clinical Program	**Cigna TheraCare® Program** – a targeted condition drug therapy management program that supports individuals using specialty medications for certain chronic conditions and helps them better understand their condition, medication side effects and importance of adherence.	**Included at No Additional Cost**

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Your Health First	A proactive health education and improvement program for Members with a chronic condition. The program involves services that span across the Member's health needs. Behavioral coaching principles and evidence based medicine guidelines are utilized to optimize self-management skills and foster sustained health improvements. The program targets a chronic population at high and moderate risk for near term and future high cost medical expenses. Members are identified as having a chronic condition through a variety of sources which may include: claims data, referrals, and self-identification. A variety of resources is provided to those with a chronic condition, including access to online tools, personalized support, and targeted materials. The program includes the following components for those with a chronic condition: • Chronic condition-specific coaching • Pre- and post-discharge calls • Lifestyle management coaching: stress, weight management and tobacco cessation • Treatment decision support and coaching In order to continuously assess the effectiveness of the program and/or test new ideas to further engage Members around their health, a small sample of Members may be placed in a comparison group which for a defined period of time receives alternative services or is suppressed from receiving proactive outreach, such as engagement letters and/or calls. This could affect a few Members targeted for outreach during this limited time period.	**For HSA OAP, OAPIN, and LCPIN Products: Included in Medical Access Fee**

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Exhibit A - Plan Booklet

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

ATTORNEYS' EYES ONLY

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Exhibit B – Services

BANKING AND ADMINISTRATION		
Products excluding Health Savings Account		
1.	Furnishing CHLIC's standard Bank Account activity data reports to Employer as and when agreed upon. CHLIC's administration of the Plan does not include performing obligations, if any, under state escheat or unclaimed property laws. It is Employer's responsibility to determine the extent to which these laws may apply to the Plan and to comply with such laws.	**All Products**
2.	Report to Employer the claim payment information required in connection with Section 6041of the Internal Revenue Code.	**All Products**
3.	If Employer has elected, pursuant to section 63 of the New York Health Care Reform Act of 1996 (section 2807-t of the Public Health Law) ("the Act"), to pay the assessment on covered lives set forth in section 63 and has consented to the conditions set forth in section 63, CHLIC shall file such forms and pay such surcharge and assessment on covered lives on behalf of Employer through the Bank Account to the extent set forth in section 63. Such obligation shall end immediately upon Employer's failure to provide any information required by CHLIC to fulfill this obligation, the failure to comply with any requirement imposed upon Employer pursuant to the Act or the failure of Employer to properly fund the Bank Account. In addition, where permitted and agreed to by CHLIC, CHLIC will file applicable forms and pay on behalf of Employer and/or the Plan any assessment, surcharge, tax or other similar charge which is required to be made by Employer and/or the Plan based on covered lives and/or paid claims or otherwise in accordance with and as required by other applicable state and/or federal laws and regulations and the Bank Account will be charged for any such payments made by CHLIC.	**All Products**
CLAIM ADMINISTRATION		
Products excluding Health Savings Account		
1.	Calculate benefits, check and/or electronic payments disbursed from Employer's Bank Account. Bank Account payments will appear in Employer's standard Bank Account activity data reports.	**All Products**
2.	CHLIC's generic claim forms are made available to Employer for individuals eligible to enroll in the Plan.	**All Products**
3.	CHLIC's Special Investigations Unit will investigate, pend, recommend denial of claims in whole or in part, and/or reprocess claims, as appropriate.	**All Products**
4.	Discuss claims, when appropriate, with providers of health services.	**All Products**
5.	Perform, based on CHLIC's book of business internal audits of plan benefit payments on a random sample basis.	**All Products**

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6.	Claim control procedures reported annually in Statement on Standards for Attestation Engagements (SSAE) No. 18 Report (or any applicable successor thereto).	**All Products**
7.	Respond to Insurance Department complaints.	**All Products**
8.	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Products**
9.	Member Explanation of Benefit ("**EOB**") statements including, when applicable, notice of denied claims, denial reason(s) and appeal rights.	**All Products (excluding Pharmacy)**
10.	Verify enrollment and eligibility using Member information submitted by Employer and/or its authorized agent.	**All Products**
	Medical Only	
1.	CHLIC's generic enrollment form is made available to Employer for individuals eligible to enroll in the Plan.	**All Medical Products**
2.	CHLIC's standard ID card with toll-free telephone number are prepared and mailed directly to Members.	**All Medical Products**
3.	Administration of subrogation/conditional Claim Payment (terms described in Exhibit E).	**All Medical Products**
	HEALTH SAVINGS ACCOUNT	
	Administration	
1.	Provision of Health Savings Account: CHLIC shall provide to Employer enrollment materials for Health Savings Accounts ("**HSA**") at a bank or other authorized entity with which CHLIC contracts (the "Bank Vendor") for Employer's employees enrolled in an eligible High Deductible Health Plan ("**HDHP**"). CHLIC and/or the Bank Vendor shall provide to Employer's eligible employees who open an HSA ("**HSA Account Holder**") telephonic and Internet customer service, debit cards, HSA checks (option made available to HSA account holders from the bank) to access HSA funds, required IRS forms such as the 1099 and 5498 and access to Individual Summary Statements that reflect account activity. CHLIC shall provide to Employer its standard reports of aggregate non-identifiable information concerning the administration of the HSA.	**HSA Product**
2.	Claim Forwarding: Each HSA Account Holder may elect to have claims not payable under the HDHP paid from funds in the Account Holder's HSA, to the extent that funds are available in such account ("**Claim Forwarding**"), whether or not the expense is a qualified IRS medical expense. Claim Forwarding is only available for payments due medical providers. Claim Forwarding is not available for pharmacy expenses.	**HSA Product**
3.	Use of HSA: HSA Account Holders are solely responsible to use HSA funds as permitted by law, including Section 223(a) of the Internal Revenue Code, to qualify for applicable tax benefits.	**HSA Product**

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4.	Enrollment in High Deductible Health Plan - Employer acknowledges that its prompt furnishing of complete and accurate HDHP eligibility and benefit information, including prompt depositing of contributions, is essential to the timely and efficient administration of its employees' health savings accounts and impacts bank ability to respond to employee account withdrawals or payments. It is understood that employee HDHP coverage terminations, including default terminations whether or not caused by employer failure to reconcile employee eligibility when so requested by CHLIC, could result in health savings account tax consequences for the employee and/or in interrupting the employee's eligibility to make health savings account contributions.	**HSA Product**
5.	Access Codes. Employer shall ensure that each authorized user establishes an Access Code for access to the Online Portal. Employer shall further ensure that authorized users safeguard all Access Codes and shall be responsible for all use of Access Codes.	**HSA Product**
6.	Online Portal. Access to the Online Employer Portal delivered by the Bank Account Administrator shall be in accordance with such manuals, training materials, terms of use, administrative control procedures, terms and conditions, and other information as shall be provided to Employer from time to time and Employer shall ensure access to Online Employer Portal complies with any such information and materials. Employer's authorized users may be assigned different levels of access. Some of the functions that Employer may access on the Portal are: 1) view reserve funding account balance and activity; 2) fund up to 2000 participants using a CSV template; 3) perform manual funding of employee bank accounts; 4) download various reports; 5) learn of upcoming changes in HSA rules; 6) use the links and tools for HSA education and additional information.	**HSA Product**
7.	Employer agrees that any access, transaction, or business conducted using the Online Employer Portal is presumed by CHLIC to have been in compliance with HSA Plan Administration under Section 223(a) of the Internal Revenue Code. Any unauthorized use of the Online Employer Portal or any Access Code shall be solely the responsibility of the Employer.	**HSA Product**
	Employer Responsibilities	
1.	HSA Contributions - Employer will facilitate pre-tax payroll contributions by HSA Account Holders. Employer may elect to make its own contributions to HSA. Employer shall send HSA Account Holder contributions plus any Employer contributions directly to the Bank Vendor.	**HSA Product**
2.	Eligibility and Enrollment - Employer is responsible for distributing to eligible employees the HSA enrollment application and documents provided to Employer by CHLIC and the Bank Vendor. Employer will submit completed HSA enrollment applications to CHLIC and/or Bank Vendor, as indicated, in the established timeframe. It is understood and agreed that an eligible employee's HSA cannot be opened until the Bank Vendor has received all necessary documents and information and has determined the HSA can be established.	**HSA Product**
3.	Information Verification - Employer shall verify information provided to CHLIC and Bank Vendor that is necessary for the establishment of the HSA. It is understood that the Bank Vendor shall rely on such information and verification in establishing and maintaining the HSA and in reporting required by law.	**HSA Product**

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ATTORNEYS' EYES ONLY

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Administrative Services Only Agreement

	Bank Vendor Relationship	
1.	Employee Agreement with Bank – Eligible employees wishing to enroll in an HSA may be required to execute certain bank documents including a custodial agreement. Approved eligible employees will become Account Holders and contract directly with the Bank Vendor for the establishment and maintenance of the HSA, including the issuance of debit cards and checks.	**HSA Product**
2.	Investment of Account Funds – While Bank Vendor offers various investment options in connection with the funds in the HSA, the HSA Account Holder is solely responsible for selecting and approving the investment vehicles into which their HSA funds will be invested. HSA Account Holders exercise sole investment discretion over their HSA investments.	**HSA Product**
3.	Bank Fees – CHLIC pays Bank Vendor to administer the HSA Accounts.	**HSA Product**
4.	Bank Fees to Accountholder – It is understood that there are separate account fees charged each HSA Account Holder by the Bank Vendor pursuant to terms communicated to HSA Account Holders through separate bank documents.	**HSA Product**
	Termination	
1.	Termination of HSA Account Holder's HDHP or of Services Under This Exhibit – Free Agents: In the event of the termination of an HSA Account Holder's HDHP coverage through CHLIC, the HSA Account Holder becomes a "**Free Agent**". Similarly, should CHLIC's HSA services under this Exhibit be terminated for any reason, either for a specific employee, or for the Employer as a whole, the affected HSA Account Holders shall from that point on be Free Agents. For Free Agents: (1) CHLIC shall no longer provide HSA services; (2) Any terms of this Exhibit shall no longer be applicable; (3) HSA shall continue to be maintained by the Bank Vendor directly not in its role as a contractor to CHLIC; (4) Bank Vendor shall issue new account numbers, debit cards, checks etc. to Free Agents; and (5) Bank Vendor shall inform Free Agents of the new applicable schedule of bank fees. Even if HSA Account Holders continue HDHP coverage through COBRA, they are still considered Free Agents for purposes of HSA services hereunder.	**HSA Product**
2.	Retroactive Terminations: It is understood and agreed that although this ASO Agreement contemplates instances in which an employee's HDHP coverage may be retroactively terminated, there will be no retroactive terminations with respect to HSA services provided hereunder. Termination of an employee's HDHP coverage or termination of an HSA shall result in the termination of services rendered under this Exhibit and the applicable fees, effective as of the end of the month that CHLIC receives notice of such termination.	**HSA Product**

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	Effect of HSA Plan on ASO Agreement Terms	
	All applicable provisions of the ASO Agreement apply to the HSA Services described in this Exhibit. In the event of a conflict between any provision of the ASO Agreement and the terms of the Exhibit with respect to the HSA services, the terms of this Exhibit shall govern.	**HSA Product**
	PLAN BOOKLET	
	Products excluding Health Savings Account	
	Prepare and make accessible Member benefit booklet drafts to Employer.	**All Products**
	UNDERWRITING SERVICES	
1.	5500 Schedule C reporting.	**All Products**
2.	5500 Schedule A or Annual Reconciliation Disclosure reporting (when applicable)	**All Products**
3.	CHLIC's standard Underwriting services: a) benefit design analysis-b) projected cost analysis.	**All Products**
	HIPAA INDIVIDUAL RIGHTS	
	Products excluding Health Savings Account	
	Handling of requests from Members for access to, amendment and accounting of protected health information, and requests for restrictions and alternative communications as required under federal HIPAA law and regulations, as set out in this Agreement and its Exhibits.	**All Products**
	COST CONTAINMENT	
1.	Maximum reimbursable charge determinations of non-Participating Provider charges for covered services.	**All Medical Products (with out-of-network benefits)**
2.	CHLIC's standard cost containment controls: Application of non-duplication and coordination of benefits rules and coordination with Medicare.	**All Medical Products**
3.	Delivery of information, as necessary, regarding standard application of non-duplication or coordination of benefits.	**All Medical Products**
4.	Review of medical bills in accordance with CHLIC's then current Medical Bill Review program.	**All Medical Products**
5.	Network Savings Program, a national vendor network that provides discounted rates when a Member accesses care through a Network Savings Program contracted provider.	**All Medical Products**
6.	Annual reporting of CHLIC's standard cost containment results upon Employer's request.	**All Medical Products**

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Administrative Services Only Agreement

	CUSTOMER REPORTING	
1.	Summary reports of medical cost and utilization experience (where applicable), upon completion of internal report generation, are available through Cigna's web site, CignaAccess.com.	**All Medical Products**
2.	Claim Reporting: CHLIC will provide standard banking and financial report information based upon paid claim data. CHLIC will not provide information on incurred-but-not reported claims, projected claims, pre-certifications of coverage, case management information or information on a Member's prognosis or course of treatment. Stop Loss Reporting is an optional service provided at an additional fee to Employers who have stop loss through another entity other than CHLIC. CHLIC will provide its standard reporting only after the stop loss carrier and Employer have executed CHLIC's standard Hold Harmless/Confidentiality Agreement.	**All Medical Products**
	MEMBER EXTERNAL REVIEW PROGRAM	
	CHLIC contracts with a minimum of three (3) independent review organizations that meet the Patient Protection and Affordable Care Act (PPACA) external review requirements. Members may appeal eligible claims requiring medical judgment to an external independent review organization which is selected by CHLIC on a random basis. If Employer has chosen not to participate in this program, the Employer may be responsible for making other arrangements to meet the Patient Protection and Affordable Care Act (PPACA) external review requirements.	**All Medical Products**
	MEDICAL MANAGEMENT SERVICES	
	CHLIC provides integrated medical management that includes (depending upon the terms of the Plan) the following core services.	
1.	Pre-Admission Certification and Continued Stay Review (PAC/CSR) services to certify coverage of acute and sub-acute inpatient admissions/stays or provides guidance to appropriate alternative settings. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products**
2.	Case Management and Retrospective Review of Inpatient Care, a service designed to provide assistance to a Member who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support.	**All Medical Products**
3.	Assist providers with resources and tools to enable them to develop long term treatment plans in the management of chronic or catastrophic cases.	**All Medical Products**
4.	The Cigna HealthCare Healthy Babies® Program is a one-time educational mailing which provides Participants with prenatal care education and resources to help them better manage their pregnancy. Other benefits of this program include the 24-Hour Health Information Line℠ and pregnancy information on myCigna.com.	**All Medical Products**
5.	HealthCare Cost and Quality tools on myCigna.com	**All Medical Products**
6.	A panel of physicians and other clinicians to assess the safety and effectiveness of new and emerging medical technologies. The panel meets monthly to review and update coverage policies.	**All Medical Products**

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7.	The 24-Hour Health Information Line℠ is a service that provides twenty-four (24) hour toll free access to nurses, who provide answers to healthcare questions, recommend appropriate settings for care and assist Participants in locating physicians. It also includes access to an extensive audio library on a wide range of medical topics.	**All Medical Products**
8.	Cigna LifeSOURCE Transplant Network® contracts with more than one hundred sixty-five (165) independent transplant facilities which includes over seven hundred fifty (750) transplant programs and provides access to solid organ and bone marrow/stem cell transplantation while improving cost containment and reducing financial risk.	**All Medical Products**
9.	A health education program that delivers mailings to Members with certain conditions.	**All Medical Products Except Comprehensive and Indemnity**
10.	If behavioral health services are provided/arranged by Cigna Behavioral Health (CBH), CBH provides utilization review and case management for both inpatient and outpatient, in-network behavioral health services.	**HSA OAP, OAPIN and LCPIN Products Only**
11.	Implement clinical quality measurements, track and validate performance and initiate continuous quality improvement.	**All Medical Products Except Comprehensive and Indemnity**
12.	Transition of care services to allow Members with defined conditions to continue treatment with non-Participating Providers after enrollment for continued uninterrupted care for a limited time.	**All Medical Products Except Comprehensive and Indemnity**
13.	Focused utilization management of outpatient procedures and identification of appropriate alternatives. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products with PHS Plus**

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ATTORNEYS' EYES ONLY

Client Name: [redacted]
Administrative Services Only Agreement

	NETWORK MANAGEMENT SERVICES	
	CHLIC, and/or its affiliates or contracted vendors shall:	
1.	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, fixed per person per period, per diem charges, incentive bonuses, case rates, withholds etc.). The amount and type of negotiated reimbursement may vary depending upon the type of plan. For example, a hospital may accept less for patients enrolled in certain types of plans than others; In addition, CHLIC may contract with Participating Providers and other parties (for example Independent Practice Associations) for performance-based incentive payments to promote quality of care, patient safety and cost efficiency.	**All Medical Products**
2.	Credential and re-credential Participating Providers in accordance with CHLIC's credentialing requirements and ensure that third-party network vendors credential/re-credential Participating Providers in accordance with CHLIC's requirements;	**All Medical Products**
3.	Monitor Participating Provider compliance with protocols and procedures for quality, Member satisfaction, and grievance resolution;	**All Medical Products**
4.	Facilitate the identification of Participating Providers by Members; and	**All Medical Products**
5.	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Medical Products**
6.	Access to online and/or on demand medical and health-related consultations via secure telecommunications technologies, telephones and internet where permitted only when delivered by a CHLIC contracted medical Telehealth network of providers (see details on myCigna.com).	**All Medical Products**
	BEHAVIORAL HEALTH	
	CHLIC has contracted with an affiliate, Cigna Behavioral Health ("CBH"), to provide or arrange for the provision of managed in-network behavioral health services, CBH is a Participating Provider, and is reimbursed primarily on a monthly fixed fee basis This fixed fee for CBH services will be paid as claims and will appear in Employer's monthly reporting and on financial documents. Such payments will be at the relevant monthly rates then in effect. The monthly rates paid to CBH vary depending on geographic location of Members and on benefit design, and may be subject to change. The rates will be made available upon request. The fixed fee also includes lifestyle management programs and a cognitive behavioral modification program. Behavioral claims from a client specific network are not included in the behavioral monthly fixed fee and will be paid from the Bank Account. In some states, payment for behavioral health services must be paid on a fee-for-service basis. In these states, fee-for-service payments for behavioral health services and the CBH administrative fee (including the lifestyle management programs and a cognitive behavioral modification program) will be paid from the Bank Account as claims and will appear in Employer's monthly reporting.	**These services are included in the following products: HSA OAP, OAPIN, and LCPIN**

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

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Client Name: [redacted]
Administrative Services Only Agreement

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

EFFECTIVE JUNE 1, 2016

(Applicable to all Open Access Plus Products)

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

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

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

CMG pharmacy rates (30-day supply):

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

Generic: AWP – 35% + $2.75 dispensing fee

Client Name: [redacted]
Administrative Services Only Agreement

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

EFFECTIVE JUNE 1, 2016

(Applicable to LocalPlus Products)

Department	CPT Code*	Description	LocalPlus Rate
All Departments	99213	OFFICE VISIT,EST EXP PROB FOC	$65.80
Adult Medicine	99396	WELL EXAM, EST, 40-64 YEARS	$102.94
Pediatrics	99392	WELL EXAM, EST, 1-4 YEARS	$85.77
Ophthalmology	66984	REMOVE CATARACT, INSERT LEN-Professional Fee only, at a facility	$700.01
Podiatry	11721	DEBRIDEMENT NAIL SIX OR MORE	$39.95
Radiology	71020	CHEST X-RAY, PA & LAT	$30.38
Radiology	G0202 + 77052	SCREENING MAMMOGRAPHY DIGITAL	$141.02
General Surgery	47562	LAPAROSCOPY;CHOLECYSTECTOMY-Professional Fee only, at a facility	$837.79
Optometry	92014	EYE EXAM & TREATMENT	$109.35
Lab	80053	COMPREHENSIVE METABOLIC PANEL	$7.66
Lab	80061	LIPID PANEL	$9.44
ASC (Ambulatory surgical center) / Endoscopy Suite	Grouper 2		$469.00
ASC (Ambulatory surgical center) / Endoscopy Suite	Grouper 8		$1,104.00

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

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

CMG pharmacy rates (30-day supply):

Brand Name: AWP – 10.56% + $2.75 dispensing fee
Generic: AWP – 35% + $2.75 dispensing fee

Exhibit C – Claim Audit Agreement (Sample)

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

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

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

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

1. Audit Specifications

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

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

2. Review of Specifications

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

3. Access to Information

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

4. Audit Report

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

5. Comment on Audit Report

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

Client Name: [redacted]
Administrative Services Only Agreement

6. Confidentiality

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

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

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

7. Restricted Use of the Audit Information

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

8. Termination

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

Client Name: [redacted]
Administrative Services Only Agreement

Cigna Health and Life Insurance Company

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date: _____

Employer: _____

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date: _____

Auditor: _____

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date: _____

Client Name: [redacted]
Administrative Services Only Agreement

Exhibit D – Privacy Addendum

("Business Associate Agreement")

This Business Associate Agreement ("Agreement") supplements, amends and is made a part of the services arrangement ("Services Arrangement"), between [redacted] (the "Company", "Employer," or "Plan Sponsor") with respect to the covered health care components of the [redacted] (collectively such covered health components are referred to as the "Covered Entity" or "Plan") and CIGNA Health and Life Insurance Company, ("Associate"), and is effective as of the effective date of the Services Arrangement (the "Agreement Effective Date"), except as otherwise provided below. This Agreement supersedes and replaces any prior Business Associate Agreement between Associate and Covered Entity or the Company on behalf of Covered Entity. Covered Entity, Company, and Associate will be parties to this Agreement.

RECITALS

WHEREAS, the Services Arrangement requires Associate to have access to and/or to collect or create Protected Health Information ("PHI") in order to carry out Associate's functions on behalf of Covered Entity;

WHEREAS, Covered Entity and Associate intend to protect the privacy and provide for the security of PHI disclosed, collected or created by Associate pursuant to the Services Arrangement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), and the regulations promulgated thereunder with respect to the privacy and security of PHI, including, without limitation, the regulations codified at 45 CFR Parts 160 and 164 (the "Regulations"), and other applicable laws including the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"), in each case, as amended from time to time;

WHEREAS, the Regulations require Covered Entity to enter into an agreement with Associate containing certain requirements with respect to the use and disclosure of PHI and which are contained in this Agreement;

WHEREAS, the Security Standards adopted pursuant to HIPAA (the "Security Standards") require Covered Entity to amend the Business Associate Agreement to include certain requirements with respect to the creation, receipt, maintenance and transmission of electronic PHI ("ePHI") and which are contained in this Agreement; and

WHEREAS, Covered Entity is a "hybrid entity," as such term is defined in section 164.504 of the Regulations, that has designated those of its components that constitute "health care components," as such term is defined in section 164.103 of the Regulations, has documented such designation as required pursuant to section 164.105(a)(2)(iii)(C) of the Regulations and has established adequate separation between such health care components and the non-health care components as required by section 164.105 of the Regulations. The terms of this Agreement will apply with respect to the designated health care components of Covered Entity.

NOW, THEREFORE, in consideration of the mutual promises contained herein and the exchange of information pursuant to this Agreement, the parties agree as follows:

1. **Definitions.** Capitalized terms used herein without definition will have the meanings ascribed thereto in the Regulations as modified by HITECH, and as amended from time to time.

2. **Obligations of Associate.**

(a) **Permitted Uses and Disclosures.** Associate may Use and Disclose PHI only as required to satisfy its obligations or as permitted under the Services Arrangement, or as permitted or required by law, but will not otherwise Use or Disclose any PHI. Associate will not Use or Disclose, and will ensure that its directors, officers and, employees do not Use or Disclose, PHI in any manner that would constitute a violation of the Regulations if done by

Covered Entity, except that Associate may Use and Disclose PHI (i) for the proper management and administration of Associate, (ii) to carry out the legal responsibilities of Associate, or (iii) to provide Data Aggregation services relating to the health care operations of Covered Entity (iv) to de-identify PHI; or (v) as permitted by 45 C.F.R. 164.512. Further, Associate will not Use or Disclose PHI unless such Use or Disclosure respectively satisfies each applicable requirement of section 164.504(e) of the Regulations.

(b) **Disclosure of Protected Health Information to Plan Sponsor.** Covered Entity acknowledges and agrees that the Regulations allow Covered Entity to permit Associate to Disclose or provide access to PHI, other than Summary Health Information or enrollment or disenrollment information, to Plan Sponsor only after Plan Sponsor has amended its plan documents to provide for the permitted and required Uses and Disclosures of PHI and to require Plan Sponsor to provide a certification to the Plan that certain required provisions have been incorporated into the Plan documents and that the Plan Sponsor agrees to abide by such provisions. The Plan Sponsor must make such amendments and provide such certification before the Plan may Disclose, either directly or through a business associate, such as Associate, any PHI to Plan Sponsor. Covered Entity hereby warrants and represents that no PHI (other than enrollment or disenrollment information) will be provided to Plan Sponsor in its capacity as Plan Sponsor or Employer or to any of its employees, agents or other persons under its control except as provided in section 2(c) of this Agreement. However, Associate understands that Plan Sponsor has made the requisite Plan document amendments and provided the appropriate certification to the Plan and will provide a copy of such certification to Associate should the need arise.

(c) **Safeguards Against Misuse of Information.** Associate agrees that it will use appropriate safeguards to prevent the Use or Disclosure of PHI other than as allowed under the terms and conditions of this Agreement or as permitted or required by law. Associate also agrees that it will reasonably and appropriately protect the Confidentiality, Integrity, and Availability of ePHI that it creates, receives, maintains, or transmits on behalf of Covered Entity by implementing (i) Administrative Safeguards as described in section 164.308 of the Regulations, (ii) Physical Safeguards described in section 164.310 of the Regulations, and (iii) Technical Safeguards described in section 164.312. The Administrative, Physical, and Technical Safeguards will be appropriate to the size and complexity of the Associate's operations and the nature and scope of its activities and will utilize the technical safeguards described in the applicable guidance issued by the Secretary in accordance with HITECH. Associate further agrees to (i) maintain a comprehensive written information privacy and security program that includes Administrative, Physical, and Technical safeguards and (ii) document such policies, procedures, actions, activities, or assessments as required under section 164.316 of the Regulations. Whenever possible, Associate agrees to secure all PHI as described in applicable guidance issued by the Secretary of Health and Human Services as described in section 13402(h)(2) of HITECH. Associate further agrees to ensure that any agent or a subcontractor, to whom it provides such ePHI agrees to implement reasonable and appropriate safeguards as described in this Section to protect the ePHI.

(d) **Duty to Mitigate.** Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a Use or Disclosure of PHI by Associate in violation of the requirements of this Agreement.

(e) **Reporting of Improper Use or Disclosure.** Associate will report to Covered Entity, a successful Security Incident and/or any Use or Disclosure of PHI other than as contemplated by the Services Arrangement and this Agreement within a reasonable time of becoming aware of such Security Incident and/or Use or Disclosure (but no later than five (5) business days thereafter), in accordance with the notice provisions set forth herein. For purposes of discovery and reporting of Breaches, Associate is not the agent of the Covered Entity or the Plan Sponsor (as "agent" is defined under common law). Associate will investigate Breaches, assess their impact under applicable state and federal law, including HITECH, and make a recommendation to the Covered Entity as to whether notification is required pursuant to 45 C.F.R. §§164.404-408 and/or applicable state breach notification laws.

(f) **Notification of Breach**

(i) **Notification to Covered Entity by Associate.** Except as required by section 164.412 of the Regulations (regarding law enforcement delay), Associate will report to Covered Entity, a Breach within a reasonable time of becoming aware of such Breach (but no later than) 5 business days thereafter. The description will include the identification of each individual whose unsecured PHI has been or is reasonably believed to have been accessed, acquired, or disclosed as a result of such Breach and any other information that Covered Entity is required to include in the notification to the individual under section 164.404(c), as described in Section 2(f)(ii) below.

(ii) **Notification to Individuals and Secretary on Behalf of Covered Entity.** With Covered Entity's approval, Associate will provide the notice required by section 164.404(c) of the Regulations to such affected Individuals in the time and manner required by section 164.404(d) of the Regulations. Such notification will (1) describe the Breach in detail, including the date of the Breach, and the date of discovery of the Breach if known, (2) describe the types of unsecured PHI that were involved in the Breach (such as whether full name, Social Security number, date of birth, home address, account number, diagnosis, disability code or other types of information were involved), (3) describe the steps, if any, individuals should take to protect themselves from potential harm resulting from the breach, (4) describe the steps that Associate is taking to investigate the breach, mitigate harm to individuals and protect against future breaches and (4) include a toll-free number provided by Associate for individuals to call to ask questions or learn additional information. In addition, in cases in which there is insufficient or out-of-date contact information that precludes written notification to the affected individual, Associate will provide a substitute notice to the affected individual as required in section 164.404(d)(2) of the Regulations and, in the event the situation is urgent, Associate may utilize any of the alternate means of providing notice described in section 164.404(d)(3) of the Regulations.

In the event that a Breach involves 500 or more Individuals and is not excepted by section 164.412 of the Regulations Associate will, to the extent applicable and practicable, and after consultation with Covered Entity and providing Covered Entity the reasonable opportunity to review and comment on any notices, provide notice to the media and the Secretary of such Breach at the same time as it notifies affected Individuals in the manner required by sections 164.406 and 164.408 of the Regulations. For Breaches involving less than 500 Individuals, Associate will maintain a log of such Breaches for each calendar year and provide – either in a consolidated log or on a case-by-case basis – to Covered Entity the information necessary by no later than January 31 of the following calendar year so that Covered Entity, or Associate on its behalf, can make the notification to the Secretary required by 164.408(c). Unless Covered Entity advises Associate otherwise, within 5 business days of the date it receives notice of the log Associate will provide the notice required by section 164.408(c).

(iii) **Additional Obligations of Associate.** In order to meet its obligations under this delegation, Associate will investigate any impermissible use or disclosure of PHI and assess whether the Use or Disclosure compromises the PHI based on a risk assessment of at least the following factors (A) the nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification, (B) the unauthorized person who Used the PHI, (C) to whom the Disclosure was made, (D) whether the PHI was actually acquired or viewed and (E) the extent to which the risk to the PHI has been mitigated.

(g) **Disclosures to and Agreements by Third Parties.**

(i) **Agents and Subcontractors.** Associate will ensure that each agent and subcontractor to whom it provides PHI received from the Plan, or created by Associate on behalf of the Plan agrees in writing to Cigna response: the same restrictions and conditions with respect to PHI that apply to Associate pursuant to this Agreement. Disclosure of such PHI by Associate must comply with each applicable requirement of section 164.504(e) of

the Regulations.

(ii) **Designated Third Parties.** Upon Covered Entity's or Employer's written request, Associate will, to the extent required in connection with the underlying terms of the Services Arrangement, provide PHI and/or Other Information to certain designated third-parties who assist in administering the Plan and are authorized by Covered Entity to receive such information ("Designated Third Parties") solely for the purpose of assisting in the carrying out of Plan administration functions. Such parties may include, but are not limited to, third-party administrators, consultants, brokers, auditors, successor administrators or insurers, and stop-loss carriers. Covered Entity will enter into an agreement with each agent, and will enter into or have its agent enter into on its behalf an agreement with each subcontractor or other third party, to which it directs Associate to Disclose PHI under which such agent, subcontractor or other third party is legally bound by the same restrictions with respect to PHI that apply to Associate pursuant to this Agreement.

(iii) **Minimum Necessary.** It is acknowledged and agreed that the Regulations require Covered Entity to maintain policies and procedures to ensure that any PHI that it Uses, requests or Discloses be no more than the minimum necessary to accomplish the intended purpose. Covered Entity hereby warrants and represents that any requests that it makes for PHI to be Disclosed to it or to any third parties will be for no more than the minimum amount necessary for the intended purpose.

(h) **Access to PHI.**

(i) **Request Made to the Plan.** When an individual requests access to PHI contained in a Designated Record Set maintained by or on behalf of the Plan by Associate and such request is made directly to the Plan or Employer, the Plan will so notify Associate within five (5) business days of receipt of such request. Associate will make such PHI available directly to the individual within the time required in section 164.524 of the Regulations. Associate will provide a copy of PHI in an electronic format in the manner required under section 164.524(c).

(ii) **Request Made to Associate.** If an Individual directs a request for access to PHI contained in such Designated Record Set to Associate, Associate will provide the PHI to the individual within the time required in section 164.524 of the Regulations

(iii) **Responsibility for Denials and Responding to Requests.** In the case of either subparagraph (i) or (ii) above, the Plan delegates to Associate the duty to determine, on behalf of the Plan, whether to deny access to PHI requested and the duty to provide any required notices and review.
(iv) **Agent for the Plan.** It is understood and agreed that in all activities performed pursuant to this Section 2(h), Associate acts as agent of and on behalf of the Plan and/or Employer. When responding to an individual's request for access, it may inform such individual of that fact and that there may be other PHI about that individual created or maintained by the Plan and/or its other Business Associates and not included in Associate's response. Associate will not be responsible for performing any of the duties described herein with respect to any such other PHI.

(i) **Amendment of PHI.**

(i) **Handling of Requests by Associate.** When an individual requests amendment of PHI contained in a Designated Record Set and created or received by Associate or its subcontractors, and such request is made directly to the Plan or Employer, within five (5) working days of its request, the Plan will forward such request to Associate for handling except that the Plan will retain and handle all requests to the extent that they pertain to individually identifiable health information (i.e., enrollment information) originated by the Plan, Plan Sponsor, or its other business associates. Associate will respond to such forwarded requests as well as to

any such requests that it receives directly as required by section 164.526 of the Regulations except that Associate will forward to the Plan for handling any requests for amendment of individually identifiable health information (i.e., enrollment information) originated by the Plan, Plan Sponsor or its other business associates.

(ii) **Responsibility for Denial of Request.** With respect to those requests handled by Associate under subparagraph (i) above, the Plan delegates to Associate the duty to determine, on behalf of the Plan, whether to deny a request for amendment of any 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 Regulations. Associate will maintain a record of all requests for amendment of PHI and the disposition thereof for the term of the Services Agreement. In all other instances, the Plan retains all responsibility for handling such requests, including any denials, in accordance with the Regulations.

(iii) **Amendments by the Plan.** Whenever Associate is notified by the Plan that the Plan has agreed to make an amendment pursuant to such a request which it handles hereunder, Associate will incorporate any such amendments in accordance with section 164.526 of the Regulations.

(iv) **Agent for the Plan.** It is understood and agreed that in all activities performed pursuant to this Section 2(i), Associate acts as agent of, and on behalf of, the Plan and/or Employer. When responding to requests for amendment of PHI, Associate may inform such individual of that fact and that there may be other PHI about that individual created or maintained by the Plan and/or its other Business Associates and not included in Associate's response. Associate will not be responsible for performing any of the duties described herein with respect to any such other PHI.

(j) **Accounting Rights.**

(i) Request Made to the Plan. When an individual requests an accounting of Disclosures of PHI created or maintained by Associate on behalf of the Plan pursuant to section 164.528 of the Regulations, and such request is made directly to the Plan or Employer, the Plan will so notify Associate within five (5) business days of receipt of such request. Associate will provide the accounting to the individual within the time required in section 164.528 of the Regulations.

(ii) **Request Made to Associate.** If a Participant directs a request for such an accounting to Associate, Associate will provide the accounting to the participant within the time required in section 164.528 of the Regulations.

(iii) **Responsibility for Denial of Request.** In the case of any request for accounting under subparagraph (i) or (ii) above, the Plan delegates to Associate the duty to determine, on behalf of the Plan, whether to provide such an accounting and to provide any required notices and review in accordance with the terms of the Regulations. Associate will maintain a record of all requests for accounting of PHI and the disposition thereof for the term of the Services Arrangement. In addition, Associate will – to the extent it relates to PHI maintained in a Designated Record Set hereunder – maintain a record of all Disclosures of PHI made with respect to or on behalf of Covered Entity since the Agreement Effective Date, which record, at a minimum, will include (A) the date of the Disclosure, (B) the name of the person or entity who received the PHI and, if known, the address of such entity or person, (C) a brief description of the PHI Disclosed, and (D) a brief statement of the purpose of the Disclosure.

(iv) **Agent for the Plan.** It is understood and agreed that in all activities performed pursuant to this Section 2(j), Associate acts as agent of, and on behalf of, the Plan and/or Employer. When responding to requests for an accounting of Disclosures, Associate may inform such individual of that fact and that there may be other Disclosures of PHI about that individual made by the Plan and/or its other Business Associates and not

included in Associate's response. Associate will not be responsible for performing any of the duties described herein with respect to any such other PHI or Disclosures.

(k) **Governmental and Covered Entity Access to Records.** CHLIC Associate 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 CHLIC on behalf of the Plan, Use and Disclosure of PHI available to the Secretary for purposes of determining.

(l) **Minimum Necessary.** Associate (and its agents or subcontractors) will only request, Use and Disclose the minimum amount of PHI necessary to accomplish the purpose of the request, Use or Disclosure in accordance with section 164.502(b) of the Regulations, section 13405(b)(1) of HITECH, and subsequent guidance issued by the Secretary of Health and Human Services, as applicable. Covered Entity hereby warrants and represents that any requests that it makes for PHI to be disclosed to it or to any third parties will be for no more than the minimum amount necessary for the intended purpose.

(n) **Privacy Laws.** The parties will comply with state privacy laws to the extent that such state privacy laws apply to the parties' performance hereunder and are not preempted by HIPAA.

3. **Obligations of Covered Entity.**

(a) **Notice of Privacy Practices.** Covered Entity will upon request provide Associate with a copy of its notice of privacy practices that Covered Entity produces in accordance with section 164.520 of the Regulations as well as any changes to such notice

(i) **Restrictions on PHI.** Covered Entity will notify Associate of any restriction to the Use or Disclosure of PHI that Covered Entity has agreed to in accordance with section 164.522 of the Regulations, to the extent that such restriction may affect Associate's Use or Disclosure of PHI pursuant to the terms of this Agreement. Associate agrees to comply with a restriction to which Covered Entity has agreed; provided, however, that Covered Entity shall not, unless required by section 164.522, agree to a restriction that would hinder Associate's performance under this Agreement and the Services Arrangement.

4. **Termination.**

(a) **Breach.** Upon Covered Entity's knowledge of a material breach of this Agreement by Associate, Covered Entity will provide not less than twenty (20) days written notice of its intent to terminate the Services Arrangement if Associate does not cure such material breach no later than the end of the written notice period. If Associate does not cure the breach within such time, then Covered Entity may, in its sole discretion, terminate the Services Arrangement, if feasible.

(b) **Effect of Termination.** The parties hereto agree that if it is not feasible for Associate to return or destroy PHI at termination of the Services Arrangement, the provisions of this Agreement will survive termination of the Services Arrangement and Associate will limit any further Uses and Disclosures of such PHI to the purpose or purposes which make the return or destruction of such PHI infeasible.

5. **Indemnity.** The indemnity provisions in the Services Arrangement will control this Agreement.

6. **Disclaimer.** Covered Entity makes no warranty or representation that compliance by Associate with this Agreement, HIPAA or the Regulations will be adequate or satisfactory for Associate's own purposes.

Client Name: [redacted]
Administrative Services Only Agreement

7. **Amendment.** In the event of a material change in the HIPAA Regulations or state law affecting the Use or Disclosure of PHI that necessitates amendment of this Agreement, the parties will negotiate in good faith to amend this Agreement accordingly.

8. **No Third Party Beneficiaries.** Nothing express or implied in the Services Arrangement or this Agreement is intended to confer, nor will anything herein confer, upon any person other than Covered Entity, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

9. **Effect on Services Arrangement.** Except to the extent inconsistent with this Agreement, all other terms of the Services Arrangement will remain in full force and effect.

10. **Interpretation.** The provisions of this Agreement will prevail over any provisions in the Services Arrangement that may conflict or appear inconsistent with any provision in this Agreement. This Agreement and the Services Arrangement will be interpreted as broadly as necessary to implement and comply with HIPAA and the Regulations. The parties agree that any ambiguity in this Agreement will be resolved in favor of a meaning that complies and is consistent with HIPAA and the Regulations, each as amended. References to the Regulations or any specific section of the Regulations will be deemed to (a) include any amendments made from time to time, including amendments required by HITECH and (b) be a reference to any successor provisions of such rule.

11. **Governing Law.** This Agreement will be construed in accordance with the laws of the State set forth in the Services Arrangement.

12. **Notices.** All notices required or permitted under this Agreement will be given in accordance with the Services Arrangement.

Exhibit E – Conditional Claim/Subrogation Recovery Services

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

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

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

___ Employer
___ An independent recovery vendor whose name and address follow:
Name:
Address:

___ CHLIC and its subcontractor(s)

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

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

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

Name:
Title:
Address:
Telephone:

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

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

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

Client Name: [redacted]
Administrative Services Only Agreement

II. Plans with CHLIC Stop Loss Coverage

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

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

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

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

Client Name: [redacted]
Administrative Services Only Agreement

Exhibit F - [redacted]

[redacted]

EXHIBIT D

Administrative Services Only Agreement

By and Between

[redacted]

"Employer"

And

Cigna Health and Life Insurance Company
"CHLIC"

And

[redacted]

Effective Date: January 1, 2015

THIS AGREEMENT AND ITS TERMS ARE PROPRIETARY AND CANNOT BE DISCLOSED WITHOUT THE PERMISSION OF EACH OF THE PARTIES

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Client Name: [redacted]
Administrative Services Only Agreement

THIS AGREEMENT, effective January 1, 2015 (the "**Effective Date**") is by and between [redacted] ("**Employer**") and Cigna Health and Life Insurance Company ("**CHLIC**") and [redacted]

RECITALS:

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

WHEREAS, Employer has requested CHLIC and [redacted] to furnish certain administration services in connection with the Plan 3335115.

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

Definitions

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

Applicable Law – means the state, federal and international laws and regulations that apply. Applicable Law includes but is not limited to the Employee Retirement Income Security Act of 1974, as amended and the rules and regulations thereunder ("**ERISA**"), the Health Insurance Portability and Accountability Act of 1996, as amended and the rules and regulations thereunder ("**HIPAA**"), the Foreign Corrupt Practices Act ("**FCPA**") and any other anti-bribery or anti-corruption laws in the countries where the Parties conduct business.

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

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

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

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

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

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

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

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

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

Run-Out Claims – claims for Plan Benefits relating to health care services and products that are incurred prior to termination of this Agreement; termination of a Plan benefit option or termination of eligible Members, as applicable.

Client Name: [redacted]
Administrative Services Only Agreement

Section 1. Term and Termination of Agreement

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

i. The date which is at least sixty (60) days from the date that either Party provides written notice to the other Party of termination of this Agreement;

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

iii. The date upon which Employer fails to fund the Bank Account as required by this Agreement or fails to pay CHLIC any charges identified in this Agreement when due provided CHLIC notifies Employer of its election to terminate;

iv. Any other date mutually agreed upon by the Parties.

Section 2. Claim Administration and Additional Services

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

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

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

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

Section 3. Funding and Payment of Claims

a. Employer shall establish a Bank Account, and maintain in the Bank Account an amount sufficient at all times to fund checks written on it for the following (collectively "**Bank Account Payments**"): (i) Plan Benefits; (ii) those charges and fees identified in the Schedule of Financial Charges as payable through the Bank Account and (iii)

any sales or use taxes, or any similar benefit- or Plan-related charge or assessment however denominated, which may be imposed by any governmental authority. Bank Account Payments may include without limitation: (i) fixed per person payments and pay-for-performance incentive payments to Participating Providers; (ii) amounts owed to CHLIC; and (iii) amounts paid to CHLIC's affiliates and/or subcontractors for, among other things, network access or in- and out-of network health care services/products provided to Members. CHLIC may credit the Bank Account with payments due Employer under a stop loss policy issued by CHLIC or an affiliate.

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

c. In the event that sufficient funds are not available in the Bank Account to pay all Bank Account Payments when due, CHLIC shall cease to process claims for Plan Benefits including Run-Out Claims.

d. CHLIC will promptly adjust any underpayment of Plan Benefits by drawing additional funds due the claimant from the Bank Account. In the event CHLIC overpays a claim for Plan Benefits or pays Plan Benefits to the wrong party, it shall take all reasonable steps to recover the overpayment; however, CHLIC shall not be required to initiate court, mediation, arbitration or other administrative proceedings to recover any overpayment. CHLIC shall not be responsible for reimbursing any unrecovered payments of Plan Benefits unless made as a result of its gross negligence or intentional wrongdoing.

e. Employer shall promptly reimburse CHLIC for any Bank Account Payments paid by CHLIC with its own funds on Employer's behalf and no such payment by CHLIC shall be construed as an assumption of any of Employer's liability.

f. Following termination of this Agreement, Employer shall remain liable for payment of all due Bank Account Payments and for all reimbursements due Members under the Plan.

This Section 3 shall survive termination of this Agreement.

Section 4. Charges

a. Charges. CHLIC shall provide to Employer a monthly statement of all charges Employer is obligated to pay under this Agreement that are not paid as Bank Account Payments. Payment of all billed charges shall be due on the first day of the month, as indicated on the monthly statement. Payments received after the last day of the month in which they are due, shall be subject to late payment charges, from the due date at a rate calculated as follows: the one (1) year Treasury constant maturities rate for the first week ending in January plus five percent (5%). For purposes of calculating late payment charges, payments received will be applied first to the oldest outstanding amount due. CHLIC may reasonably revise the methodology for calculating late payment charges upon thirty (30) days' advance written notice to Employer.

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

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

This Section 4 shall survive termination of this Agreement.

Client Name: [redacted]
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Section 5. Enrollment and Determination of Eligibility

a. Eligibility Determinations and Information. Employer is responsible for administering Plan enrollment. In determining any person's right to benefits under the Plan, CHLIC shall rely upon enrollment and eligibility information provided by the Employer. Such information shall identify the effective date of eligibility and the termination date of eligibility and shall be provided promptly to CHLIC in a format and with such other information as reasonably may be required by CHLIC for the proper administration of the Plan.

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

c. Reconciliation of Eligibility and Information and Default Terminations. CHLIC will periodically share potential discrepancies in eligibility information with Employer. Employer will review and reconcile any discrepancies within thirty (30) days of receipt. If Employer fails to timely do so, CHLIC may terminate coverage for any Member not listed as eligible in Employer's submitted eligibility information.

Section 6. Claim Audits and Confidentiality

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

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

ii. If Employer has five thousand (5,000) or more employees who are Members, Employer may conduct one such audit every Plan Year (but not within six (6) months of a prior audit); otherwise, Employer may conduct one such audit every two (2) Plan Years (but not within eighteen (18) months of a prior audit).

iii. Auditor will review payment documents (subject to any contrary terms in Participating Provider agreements) 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. If the audit identifies any claim adjustments, any such adjustments will be made in accordance with this Agreement and based upon the actual claims reviewed and not upon statistical projections or extrapolations.

b. Confidentiality

i. Subject to the requirements of Applicable Law, the terms of this Agreement and the Privacy Addendum in Exhibit D, a signed Business Associate agreement between Employer and its designee, and a signed Confidentiality Agreement between CHLIC and applicable designee; CHLIC shall release copies of confidential claims and Plan Benefit payment information in CHLIC's claims system ("**Confidential Information**") and may release copies of proprietary information relating to the Plan in CHLIC's claims system ("**Proprietary Information**") to the Employer and/or its designees. Employer agrees that Employer

and its designees will keep Confidential Information and Proprietary Information confidential and will use Confidential Information and Proprietary Information solely for the purpose of administering the Plan or as otherwise required by law. Employer is solely responsible for the consequences of any use, misuse, or disclosure of Confidential Information provided by CHLIC pursuant to this paragraph b.

ii. CHLIC will maintain the confidentiality of all Protected Health Information in its possession in accordance with the Privacy Addendum in Exhibit D 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.

c. Upon termination of this Agreement and subject to the provisions of Section 6.b above, CHLIC shall make information available, to the extent administratively feasible, if the Parties agree upon the charge to be paid by Employer.

The obligations set forth in this Section 6 (b), shall survive termination of this Agreement.

Section 7. Plan Benefit Liability

a. Employer Liability for Plan Benefits. Employer is responsible for all Plan Benefits including any Plan Benefits paid as a result of any legal action. Employer is responsible for reimbursing CHLIC and [redacted] its directors, officers and employees for any reasonable expense incurred (including reasonable attorneys' fees) by them in the defense of any action or proceeding involving a claim for Plan Benefits. CHLIC and [redacted] shall reasonably cooperate with Employer, in its defense of such actions.

If Employer directs CHLIC in writing to pay a claim for Extra-Contractual Benefits, Employer is responsible for funding the payment and such payments shall not be considered in determining reimbursements or payments under stop loss insurance or in determining any risk-sharing or performance guarantee reimbursements. Employer shall reimburse CHLIC and [redacted] for any liability or expenses (including reasonable attorneys' fees) CHLIC or [redacted] may incur in connection with making such payments.

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

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

Section 8. Modification of Plan and Charges

a. CHLIC shall have the right to revise the charges identified in this Agreement (i) on the first anniversary of this Agreement and at any time thereafter by giving Employer at least sixty (60) days' prior written notice, but not more frequently than once in a twelve (12) month period, (ii) upon any modification or amendment of the benefits under the Plan, (iii) upon any variation of fifteen percent (15%) or more in the number of Members used by CHLIC to calculate its charges under this Agreement, and/or (iv) upon any change in law or regulation that materially impacts CHLIC's liabilities and/or responsibilities under this Agreement.

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

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Administrative Services Only Agreement

Section 9. Modification of Agreement

This Agreement constitutes the entire contract between the Parties regarding the subject matter herein. Except, as otherwise provided herein, the provisions of this Agreement shall control in the event of a conflict with the terms of any other agreements. No modification or amendment hereto shall be valid unless in writing and signed by an authorized person of each of the Parties, except that modification of charges pursuant to Section 8 above may be made by written notice to Employer by CHLIC. If Employer pays such revised charges or fails to object to such revision in writing within fifteen (15) days of receipt, this Agreement shall be deemed modified to reflect the charges as communicated by CHLIC.

Section 10. Laws Governing Agreement

a. This Agreement shall be construed in accordance with the laws of the State of Connecticut without regard to conflict of law rules, and both Parties consent to the venue and jurisdiction of its courts.

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

Section 11. Information in CHLIC and [redacted] Processing Systems

CHLIC and [redacted] may retain and use all Plan-related claim and Plan Benefit payment information recorded for or otherwise integrated into CHLIC's and [redacted] business records including claim processing systems during the ordinary course of business (provided, however, that claim or payment information will be available to Employer pursuant to Section 6). CHLIC and [redacted] will retain claim and payment information as required by Applicable Law.

Section 12. Resolution of Disputes

It is understood and agreed that any dispute between the Parties arising from or relating to the performance or interpretation of this Agreement ("**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 initiate Executive Review by giving the other Party written notice of the Controversy and shall specifically request Executive Review of said Controversy in such notice. Within twenty (20) calendar days of any Party's written request for Executive Review, the receiving Party shall submit a written response. Both the notice and response shall include a statement of each Party's position and a summary of the evidence and arguments supporting its position. Within thirty (30) calendar days of any Party's request for Executive Review, an executive level employee of each Party shall be designated by the Party to meet and confer with her/her counterpart to attempt to resolve the dispute. Each representative shall have full authority to resolve the dispute.

b. In the event that a Controversy has not been resolved within thirty-five (35) calendar days of the request of Executive Review under Section 12.a, above, the disputing Party shall initiate mediation by providing written notice to the other Party, which shall be conducted in Hartford, Connecticut, in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Mediation ("**Mediation**"). Each Party shall assume its own costs and attorneys' fees, and the compensation and expenses of the mediator and any administrative fees or costs associated with the mediation proceeding shall be borne equally by the Parties.

c. In the event that a Controversy has not been resolved by Executive Review or Mediation, the Controversy shall be settled exclusively by binding arbitration. The arbitration shall be conducted in the same location as noted in Section

12.b. above, in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration, and which to the extent of the subject matter of the arbitration, shall be binding not only on all Parties to this Agreement but on any other entity controlled by, in control of or under common control with the Party to the extent that such affiliate joins in the arbitration, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Each Party shall assume its own costs and attorneys' fees, and the compensation and expenses of the arbitrator and any administrative fees or costs associated with the arbitration proceeding shall be borne equally by the Parties. The decision of the arbitrator shall be final, conclusive and binding, and no action at law or in equity may be instituted by either Party other than to enforce the award of the arbitrator.

d. The Parties intend this dispute resolution procedure described above to be a private undertaking and agree that an arbitration conducted under this provision will not be consolidated with an arbitration involving other plans administered in whole or in part by CHLIC or [redacted] or other Cigna Corporation or [redacted] affiliate, or third parties not parties to this Agreement. The arbitrator will be without power to conduct arbitration on a class or representative basis. The Parties waive their right to participate in a class action or representative proceeding. The arbitrator may award declaratory or injunctive relief only in favor of the individual party seeking relief and only to the extent necessary to provide relief warranted by that party's individual claim. All issues are for the arbitrator to decide, except the courts will decide those issues relating to the scope and enforceability of the arbitration provision.

This Section 12 shall survive termination of this Agreement.

Section 13. Third Party Beneficiaries

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

Section 14. Waivers

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

Section 15. Headings

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

Section 16. Severability

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

Section 17. Force Majeure

CHLIC and/or [redacted] shall not be liable for any failure to meet any of the obligations required under this Agreement where such failure to perform is due to any contingency beyond the reasonable control of CHLIC and/or [redacted] their employees, officers, or directors. Such contingencies include, but are not limited to, acts or omissions of any person or entity not employed or reasonably controlled by CHLIC and/or [redacted] their employees, officers, or directors, acts of God, fires, wars, accidents, labor disputes or shortages, and governmental laws, ordinances, rules or regulations.

Client Name: [redacted]
Administrative Services Only Agreement

Section 18. Assignment and Subcontracting

No Party may assign any right, interest, or obligation hereunder without the express written consent of the other Party; provided, however that CHLIC and [redacted] may assign any right, interest, or responsibility under this Agreement to its affiliates and/or subcontract specific obligations under this Agreement provided that CHLIC or [redacted] shall not be relieved of its obligations under this Agreement when doing so.

Section 19. Notices

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

To CHLIC:
Cigna Health and Life Insurance Company
900 Cottage Grove Rd
Hartford, CT 06152
Attention: Anthony Matteo, Underwriting Director

To [redacted]
Attention: [redacted]

With a copy to:
[redacted]
Attention: [redacted]

To Employer:
[redacted]
Attention: [redacted]

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

Section 20. Identifying Information and Internet Usage

Except, as necessary in the performance of their duties under this Agreement, no Party may use the other's name, logo, service marks, trademarks or other identifying information or to establish a link to the other's World Wide Web site without its prior written approval.

Client Name: [redacted]
Administrative Services Only Agreement

SIGNATURES

IN WITNESS WHEREOF, the Parties have caused this Agreement, and all Exhibits and Addenda to this Agreement, to be executed in triplicate and signed by their respective officers duly authorized to do so as of the dates given below. Employer executes as the authorized representative of the Plan with respect to the Privacy Addendum and the [redacted] Addendum to this Agreement.

Dated at _____, _____

This _____ day of _____, _____

[redacted]

By: _____
Name:
Its
Duly Authorized

Dated at Hartford, Connecticut

This 27th day of October, 2014

CIGNA HEALTH AND LIFE INSURANCE COMPANY

By: _____
Name: Victoria A. Sirica
Its Contractual Agreement Unit Manager
Duly Authorized

Dated at _____, _____

This _____ day of _____, _____

[redacted]

By: _____
Name:
Its
Duly Authorized

Schedule of Financial Charges

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

MEDICAL ADMINISTRATION CHARGES		
Product	**Description**	**Charge**
Medical	• Open Access Plus (OAP) with PHS Plus Medical Management	**$40.33/employee/month**
Medical	• HSA Open Access Plus (OAP) with PHS Plus Medical Management- (For Non-Cobra)	**$42.02/employee/month**
Medical	• HSA Open Access Plus (OAP) with PHS Plus Medical Management- (For Cobra)	**$40.33/employee/month**
Medical	• Comprehensive with PHS Plus Medical Management	**$34.18/employee/month**
MEDICAL NETWORK ACCESS FEE, UTILIZATION MANAGEMENT FEE AND OPTIONAL PROGRAM FEE		
Product	**Description**	**Charge**
Medical	• OAP Access Fee	**$19.62/employee/month Included in Medical Administration Charge**
Medical	• HSA OAP Access Fee- (All Plans)	**$19.62/employee/month Included in Medical Administration Charge**
Medical	• Comprehensive Care Coordination Fee	**$13.47/employee/month Included in Medical Administration Charge**
CIGNA CHOICE FUND AND OTHER CONSUMER DIRECTED ACCOUNT ADMINISTRATION SERVICES AND CHARGES		
	Product	**Charge**
	• Cigna Choice Fund Health Savings Account (HSA) Administration- (For Non-Cobra)	**$1.69/employee/month Included in Medical Administration Charge**

ATTORNEYS' EYES ONLY

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Personal Health Team – A	A program that encompasses those who are at risk for a health related condition and those who are experiencing health concerns. This program centers on the use of behavioral coaching and case management principles and uses nurses and health coaches. This solution includes the following components: • Pre and post discharge calls when Cigna is the medical carrier • Inpatient advocacy calls (when permission is obtained from the Member) • Short term and complex case management • Vendor partner referral and integration • Predictive modeling outreach • Coordination with Cigna onsite programs, as appropriate • 24 hr HIL post f/u call outreach • Health Risk Assessment Outreach • Multi-session Health and wellness coaching • Treatment decision support and coaching • Gaps in care outreach and counseling • Single point of contact for continuity in the advocate/Member relationship Members are identified for participation in the Personal Health Team Program through a variety of sources including but not limited to Clinical algorithms developed and implemented by Cigna, Self-enrollment, Inpatient Admissions, Short-term and/or complex case management (medical)	**For HSA OAP (Non-Cobra) Included in Medical Access Fee**
AMOUNTS OWED TO CHLIC		
Amounts paid by CHLIC with its own funds on behalf of Employer or the Plan with respect to charges for which Employer or the Plan is obligated to pay under this Agreement including Plan Benefits, Bank Account Payments (including fix per person payments and pay-for-performance payments to Participating Providers), governmental taxes or assessments.		

	CIGNA PHARMACY BENEFIT MANAGEMENT SERVICES CHARGES AND RELATED PROVISIONS	

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Definitions

- "Average Wholesale Price" or "AWP" is the Average Wholesale Price for a given pharmaceutical product in effect on the dispense date for the actual package size dispensed as published by Medi-Span or other alternative publication or benchmark reasonably designated by CHLIC.
- "Brand Drug Claim" is a claim for a pharmaceutical product that is adjudicated as a brand drug as indicated on the claim record generated by the claim processing system used by CHLIC. For application of discounts and dispensing fees, a "Brand Drug Claim" includes a claim for a generic drug within its exclusivity period or other period of limited competition, as CHLIC reasonably determines under its standard policies.
- "Generic Drug Claim" is a claim for a pharmaceutical product that is adjudicated as a generic drug as indicated on the claim record generated by the claim processing system used by CHLIC. For application of discounts and dispensing fees, a "Generic Drug Claim" excludes a claim for a generic drug within its exclusivity period or other period of limited competition, as CHLIC reasonably determines under its standard policies.
- "Mail Service Pharmacy" or "Cigna Tel-Drug" or "Cigna Home Delivery Pharmacy" is a pharmacy that is owned or operated by CHLIC or an affiliated company(ies) (currently, Tel-Drug, Inc. and Tel-Drug of Pennsylvania, LLC), which dispenses drugs covered under the Plan's Pharmacy Benefit by mail, and is not a Retail Pharmacy.
- "Pharmacy Benefit" means the terms of the Plan that govern coverage and care/utilization management of drugs and related supplies dispensed to Members and charged to the Plan by the Mail Service Pharmacy or Retail Pharmacies through CHLIC's pharmacy claim processing system.
- "Rebates" or "Manufacturer Formulary Payments" means amounts that CHLIC collects under contracts with drug manufacturers that are based on utilization of certain of the manufacturers' brand drugs under the Plan's Pharmacy Benefit and the drug's status on the Cigna drug formulary.
- "Retail Pharmacy" is a pharmacy that is entitled to payment under the Plan for drugs it dispenses that are covered under the Plan's Pharmacy Benefit, and is not a Mail Service Pharmacy.
- "Specialty Drug Claim" is a claim for a pharmaceutical product that is reasonably determined by CHLIC to be a specialty drug in accordance with industry practice. Specialty drugs generally are (i) injected or infused and derived from living cells, or are oral non-protein compounds (e.g., oral chemotherapy drugs); (ii) target the underlying condition, which is usually one of a relatively rare, chronic and costly nature; and/or (iii) require restricted access and/or close monitoring.

PHARMACY ADMINISTRATION FEE
• Cigna Pharmacy Product Administration Fee: Included in Medical Administration Charge

CHARGES FOR DRUGS COVERED UNDER THE PLAN'S PHARMACY BENEFIT

ATTORNEYS' EYES ONLY

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Drugs Dispensed by Mail Service Pharmacy: CHLIC will charge Employer the following for claims covered under the Plan's Pharmacy Benefit and dispensed by the Mail Service Pharmacy, subject to the "Drug Charges – Additional Provisions" section:
Brand Drug Claims: AWP minus an average discount of 26.0% plus an average dispensing fee of $0.00. **Generic Drug Claims:** The drug's charge on a CHLIC generic Maximum Allowable Charge schedule that generates an annual average aggregate discount across Generic Drug Claims dispensed at Cigna Home Delivery Pharmacy to CHLIC group-client book of business of AWP minus 81.5% plus an average dispensing fee across such Generic Drug Claims of not more than $0.00. **Specialty Brand Drug Claims**: The drug's charge under a national discount schedule that generates a 14.5% annual average aggregate discount off AWP for Specialty Drug Claims dispensed at Cigna Home Delivery Pharmacy across CHLIC 's group-client book of business (including Specialty Drug Claims dispensed by Mail Service Pharmacy, whether covered under group-clients' Cigna Pharmacy Benefit or Cigna medical benefit).
Drugs Dispensed by Retail Pharmacies: CHLIC will charge Employer the following for drugs covered under the Plan's Pharmacy Benefit and dispensed by a Retail Pharmacy to the Plan Members, subject to the "Drug Charges – Additional Provisions" section:
Retail Brand Drug Claims: The lesser of (i) AWP minus an average discount of 17.3% plus an average dispensing fee of $1.00; or (ii) the Retail Pharmacy's usual and customary charge. **Retail Generic Drug Claims** (other than those to which the above brand discount applies): The lesser of: (i) the drug's charge on a CHLIC generic Maximum Allowable Charge schedule that generates an annual average aggregate discount across Generic Drug Claims dispensed at Retail Pharmacies to CHLIC group-client book of business of AWP minus 77.05% (Plan-specific results may vary based on drug mix), plus an average dispensing fee across such Generic Drug Claims of no more than $1.00; or (ii) the Retail Pharmacy's usual and customary charge. **Retail Specialty Brand Drug Claims:** The lesser of (i) AWP minus an annual average aggregate discount of 13.5%, plus an average dispensing fee of no more than $1.00; or (ii) the Retail Pharmacy's usual and customary charge.

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DRUG CHARGES – ADDITIONAL PROVISIONS
• Cigna Home Delivery Pharmacy's discounts are applied to the manufacturer average wholesale price (AWP) for the dispensed size (or to the AWP for the manufacturer-packaged quantity closest to the dispensed size, if there is no AWP for the dispensed size).
• The amount paid to the Retail Pharmacy for Brand, Generic, or Specialty Drug Claims may or may not be equal to the amount charged to Employer, and CHLIC will absorb or retain any difference.
• An excess achieved in any Plan-specific discount floor or dispensing fee cap offered under this Agreement will be used to offset a shortfall in any other Plan-specific discount floor or dispensing fee cap offered under this Agreement.
• Industry Changes to or Replacement of Average Wholesale Price (AWP). Notwithstanding any other provision in this Agreement, including in this Exhibit, in the event of any major change in market conditions affecting the pharmaceutical or pharmacy benefit management market, including, for example, any change in the markup, methodologies, processes or algorithms underlying the published AWP(s), CHLIC may adjust any or all of the charges, rates, discounts, guarantees and/or fees in connection with CHLIC's administration of the Plan's Pharmacy Benefit hereunder, including any that are based on AWP, as it reasonably deems necessary to preserve the economic value or benefit of this Agreement as it existed immediately prior to such change. Additionally, and notwithstanding any other provision in this Agreement, including in this Exhibit, CHLIC may replace AWP as its pharmaceutical pricing benchmark with an alternative benchmark and/or may replace Medi-Span, or other such publication as its source for the AWP or alternative benchmark with a different pricing source, provided that CHLIC adjusts any or all such AWP-Based Charges or such alternative benchmark-based charges as it reasonably deems necessary to preserve the economic value or benefit of this Agreement as it existed immediately prior to such replacement or immediately prior to the event(s) giving rise to such replacement, as the case may be.

ATTORNEYS' EYES ONLY

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DRUG MANUFACTURER-PAYMENT SHARING
Subject to the caveats below, CHLIC will remit to Employer the following portion of Rebates that CHLIC collects with respect to utilization under the Plan's Pharmacy Benefit: The greater of 100% of Rebates, or the sum of $5.25 multiplied by the number of Retail Pharmacy prescription claims plus $32.00 multiplied by the number of Mail Service Pharmacy prescription claims.
Caveats: (1) Upon termination of this Agreement, CHLIC may apply Rebates otherwise payable to offset Bank Account or other deficits of charges identified in this Agreement. (2) Should Employer terminate this Agreement before completion of the then-current Plan Year, no Rebates shall be due with respect to that Plan Year as Rebates are based on completion of an entire Plan Year. (3) All applicable caveats communicated in writing by CHLIC in connection with its proposal made in connection with this Agreement are hereby incorporated by reference. (4) For percentage-based sharing arrangements, payout amount may differ slightly from the stated percentage when payout occurs before manufacturers' final reconciliations and payments are made to CHLIC. (5) Rebates are not paid out on Run-Out Claims or on claims for drugs covered under the federal 340B drug pricing program. (6) CHLIC or its agent contracts with drug manufacturers on CHLIC's own behalf, and not as agent of the Employer or the Plan. Timing of Rebate Pay-Out: Remittance will be provided within ninety (90) days after the close of each applicable calendar year for the portion of such calendar year that coincides with the Plan Year.
AUDIT RIGHTS RELATED TO MANUFACTURER PAYMENTS
Employer's third party auditor may audit records directly related to CHLIC's performance of its obligations hereunder regarding sharing of manufacturer formulary payments (a/k/a "rebates") once in each twelve-month period upon the following conditions: Employer shall provide at least forty-five (45) days written notice to CHLIC; the auditor (including its individual auditors conducting the audit) shall be agreeable to Employer and CHLIC; a mutually agreed upon non-disclosure/non-use contract shall be executed by Employer, the auditor and CHLIC; the records to be audited shall be no more than two years old as of the date of the audit; the scope of records to be audited shall be as mutually agreed upon by Employer's third party auditor and CHLIC as those which are necessary to determine compliance with the rebate-sharing obligations under this Agreement; the audit shall be conducted at a mutually acceptable time during regular business hours at CHLIC's office where such records are located; records shall not be removed or photocopied without CHLIC's express written consent; the auditor shall provide its audit report to CHLIC and Employer at the same time; and the auditor may disclose the aggregate amount of manufacturer formulary payments due Employer but no other details of CHLIC's manufacturer contracts of which the auditor is apprised, if any.

ATTORNEYS' EYES ONLY

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FEES FOR PROCESSING RUN-OUT CLAIMS		
OAP, HSA OAP and Comprehensive	Run-Out Period of twelve (12) months	**No Additional Cost**
Pharmacy	Run-Out Period of three (3) months for all pharmacy claims	**No Additional Cost**
SUBROGATION		
	Subrogation/Conditional Claim Payment. Identification, investigation and recovery of claim payments involving other party liability or where another entity is responsible for payment (including by way of example but not by limitation automobile insurance, homeowner insurance, commercial property insurance, worker's compensation). (This service is only provided with respect to Medical coverage).	**5% of recovery plus litigation costs if counsel is retained and an appearance is filed on behalf of CHLIC or Employer in any litigation, or a lawsuit is filed on their behalf;** **29% of recovery if no counsel is retained and in all other instances, including cases where state law requires that employee benefit plans be named as party defendants or involuntary plaintiffs.**

ATTORNEYS' EYES ONLY

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CHLIC COST CONTAINMENT FEES		
CHLIC, a Cigna company, administers the following programs to contain costs with respect to charges for health care service/supplies that are covered by the Plan. In administering these programs, CHLIC contracts with vendors to perform program related services. Specific vendor fees are available upon request. CHLIC's charge for administering these programs is the percentage (indicated below) of either (1) the "net savings" (i.e. the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings, less the applicable vendor fee which generally ranges from 7-11% of the program savings) or (2) the "gross savings" (i.e. the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings; CHLIC pays the applicable vendor fee) or (3) the "recovery" (i.e. the amount recovered) as applicable. For charges for covered services received from a non-Participating Provider (including emergency/urgent care services that are covered at the in-network benefit level), CHLIC may apply discounts available under agreements with third parties or through negotiation of the billed charges. These programs are identified below as the Network Savings Program, Supplemental Network & Medical Bill Review (pre-payment). CHLIC charges the percentage shown for administering these programs. Applying these discounts may result in higher payments than if the maximum reimbursable charge is applied. Whereas application of the maximum reimbursable charge may result in the patient being balance billed for the entire unreimbursed amount, applying these discounts avoids balance billing and substantially reduces the patient's out-of pocket cost. If no discount is available or negotiated, reimbursement will be based upon: (i)If charges are not subject to CHLIC's benefit enhancement policy – the plan's maximum reimbursable charge (in which case the patient may be balance billed by the provider if the provider's charge exceeds the plan's maximum reimbursable charge); or (ii) If charges are subject to CHLIC's benefit enhancement policy – depending upon the Employer's election: a. the amount of provider's billed charge not exceeding the greater of a CHLIC determined percentage of the Medicare allowable amount (the 80th percentile of the reasonable and customary charge if there is no Medicare allowable charge) or the amount required by state or federal, law (in the case of emergency room services) for charges subject to CHLIC's benefit enhancement policy (patient may be balance billed by the provider if the provider's charge exceeds such amount), or b. the provider's billed charge. This administration of charges for covered services from non-Participating Providers is consistent with the claim administration practices with respect to CHLIC's own health care insurance business where applicable.		
MEDICAL AND PHARMACY COST CONTAINMENT		
1.	Network Savings Program	**29% of net savings**
2.	Supplemental Network	**29% of net savings**
3.	Medical Bill Review – (Pre-payment Cost Containment for Non-contracted claims):	
	Inpatient Hospital Bill Review	
	• Line Item Analysis	**Lesser of 5% of hospital bill or the savings achieved**

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	• Professional Fee Negotiation	**29% of net savings**
	Outpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
	Physician/Professional Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
4.	Medical Bill Review – (Pre or Post-payment Cost Containment for Non-contracted and Contracted claims):	
	• Bill Audit	**29% of the savings/recovery achieved plus hospital fees or expenses passed through**
	Diagnosis Related Grouping (DRG) Validation/Audits and Recovery. An overpayment audit and recovery program in which CHLIC or its vendors review paid claim data to identify overpayments based on inaccurate DRG coding.	**29% of recovery plus any fees or expenses passed through by the hospital or regulatory agency**
	Inpatient Admission Retrospective Review	**29% of recovery**
	Medical Implant Device Audits	**29% of recovery**
5.	COB Vendor Recoveries [Exclusive of pharmacy programs where claims are adjudicated at time prescription is received.]	**29% of recovery**
6.	Secondary Vendor Recovery Program	**29% of recovery**
7.	Provider Credit Balance Recovery Program	**29% of recovery**
8.	High Cost Specialty Pharmaceutical Audits	**29% of recovery**
9.	Pharmacy Vendor Recoveries	**30% of recovery**
10.	Class Action Recoveries	**35% of recovery**

CARE MANAGEMENT/COST CONTAINMENT PROGRAM FEES

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

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	OTHER VENDORS AND HEALTH CARE SERVICES PROVIDERS	
	Fixed per person per period and fee-for-service charges for various vendors and other providers/arrangers of health care services and/or supplies will be paid as claims for Plan Benefits. In addition, performance-based payments to Participating Providers will be charged to the Bank Account. Such payments will be at the payment rates then in effect, which may be amended from time to time. Additional details regarding charges and the identity of the vendor or provider of health care services will be made available upon request.	**All Products**
	NOTICE REGARDING PAYMENTS FROM THIRD PARTIES	
	Unless indicated otherwise in the Schedule of Financial Charges, CHLIC retains all payments it may receive from manufacturers of pharmaceutical products covered under the Plan. Information on the amount of such payments with respect to the Plan will be provided upon request.	**All Pharmacy Products**
	From time to time, CHLIC, directly or through its affiliates, arranges with third party parties (e.g., service vendors, provider network managers) to provide various services (e.g., cost-containment initiatives) in connection with the Plan. CHLIC and its affiliates may receive payments from such third parties to help defray CHLIC's expenses associated with the implementation and/or ongoing administration of these arrangements. CHLIC may also receive compensation from third-party vendors that Employer may retain based upon a referral from CHLIC.	**All Products**
	COMPLIANCE ASSISTANCE	
	CHLIC shall provide the following services to assist Employer in meeting its compliance obligations under section 2715 of the Public Health Service Act as added by the Patient Protection and Affordable Care Act and applicable regulations with respect to the provision of the Summary of Benefits and Coverage ("SBC), translation notice and glossary. Applicable to all medical plans including HRA and FSA which are considered "group health plans" subject to the SBC requirements.	
1.	Preparation of SBC, translation notice. CHLIC will not be responsible for any changes that Employer makes to the SBC.	**No charge**
2.	Provide SBC, translation notices prepared by CHLIC to Employer electronically as well as any updates or material modifications.	**No charge**
3.	Include in SBC a summary of benefits administered by carve-out vendor if Employer or carve-out vendor provides CHLIC with necessary carve-out benefit information at least twelve (12) weeks prior to the date the SBCs are to be delivered to Employer.	**$500 for each benefit option under the Plan for which carve-out vendor benefits are included in SBC**

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ADDITIONAL SERVICES		
Service	**Description**	**Charge**
Behavioral Health	Behavioral Care Advocacy provides behavioral health services in which claims are funded on a fee-for-service basis. It includes focused utilization review and case management for both inpatient and outpatient, in-network behavioral health services.	**For OAP and HSA OAP Included in Medical Access Fee**
Personal Health Team – A	A program that encompasses those who are at risk for a health related condition and those who are experiencing health concerns. This program centers on the use of behavioral coaching and case management principles and uses nurses and health coaches. This solution includes the following components: • Pre and post discharge calls when Cigna is the medical carrier • Inpatient advocacy calls (when permission is obtained from the Member) • Short term and complex case management • Vendor partner referral and integration • Predictive modeling outreach • Coordination with Cigna onsite programs, as appropriate • 24 hr HIL post f/u call outreach • Health Risk Assessment Outreach • Multi-session Health and wellness coaching • Treatment decision support and coaching • Gaps in care outreach and counseling • Single point of contact for continuity in the advocate/Member relationship Members are identified for participation in the Personal Health Team Program through a variety of sources including but not limited to Clinical algorithms developed and implemented by Cigna, Self-enrollment, Inpatient Admissions, Short-term and/or complex case management (medical)	**For OAP, Comprehensive and HSA OAP (Cobra) Included in Medical Access Fee**

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Comprehensive Maternity Program	Cigna Healthy Pregnancies, Healthy Babies program is a comprehensive maternity management program. The goal of the program is to reduce the number of pre-term and underweight babies by promoting a healthy pregnancy. The program delivers education and telephonic support to pregnant women through the post-partum period. Nurses answer medical related questions and make suggestions for behavior changes and medical interventions aimed at improving the health of the mother and baby. Program support also covers preconception and infertility. Financial incentives are awarded to women at the completion of this self-referral program based on the trimester enrolled. Members must enroll in the program by calling the phone number on the back of the Member identification card. Incentives Elected: Option 2: $250 – 1st Trimester/$125 – 2nd Trimester	**Included in the Medical Access Fee**
Comprehensive Oncology Program	The Cigna Cancer Support Program - A program designed to deliver comprehensive oncology support targeting Members through all stages of cancer; from those newly diagnosed, in post cancer care, in active treatment and with or without complications and/or end of life status. The program addresses cancer prevention through education; providing assistance to Members in active treatment, utilizing evidence based clinical resources, development of survivorship plans for cancer survivors, and supporting Members and their families with end-of-life decisions if appropriate.	**Included in the Medical Access fee**

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Pharmacy Clinical Program	**Step Therapy Program** – a prior authorization/step therapy program that encourages cost-effective clinically appropriate drug utilization and reduces costs by creating a sequence of "steps" in the choice of medication used to treat some common medical conditions.	**Included in Pharmacy Administration Charge**
Pharmacy Clinical Program	**Cigna TheraCare® Program** – a targeted condition drug therapy management program that targets individuals using specialty medications for certain chronic conditions and helps them better understand their condition, medication side effects and importance of adherence.	**Included at No Additional Cost**
Pharmacy Clinical Program	Return on Health (a/k/a "ROH" or "Cigna Well Informed") - a program under which Cigna uses its integrated position as the claims administrator for both the Plan's medical benefit and Pharmacy Benefit to manage specific types of gaps in Members' pharmacy therapy to generate annual savings to Employer of $1.00 per Member per month based on the average annual number of Members covered under the Plan's Pharmacy Benefit. Employer must have Cigna Medical, Cigna Pharmacy, Cigna Home Delivery and Cigna Well Informed in place for at least one plan year before the performance guarantee measurement begins. Penalty assessment begins in the second plan year.	**Included at No Additional Cost**

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Your Health First	A proactive health education and improvement program for Members with a chronic condition. The program involves services that span across the Member's health needs. Behavioral coaching principles and evidence based medicine guidelines are utilized to optimize self-management skills and foster sustained health improvements. The program targets a chronic population at high risk for near term and future high cost medical expenses. Members are identified as having a chronic condition through a variety of sources which may include: claims data, referrals, and self-identification. A variety of resources is provided to those with a chronic condition, including access to online tools, personalized support, and targeted materials. The program includes the following components for those with a chronic condition: • Chronic condition-specific coaching • Pre- and post-discharge calls • Lifestyle management coaching: stress, weight management and tobacco cessation • Treatment decision support and coaching In order to continuously assess the effectiveness of the program and/or test new ideas to further engage Members around their health, a small sample of Members may be placed in a comparison group which for a defined period of time receives alternative services or is suppressed from receiving proactive outreach, such as engagement letters and/or calls. This could affect a few Members targeted for outreach during this limited time period.	**For OAP, HSA OAP and Comprehensive Products: Included in Medical Access Fee**

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Exhibit A - Plan Booklet

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

Exhibit B – Services

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

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8.	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Products**
9.	Member Explanation of Benefit ("EOB") statements including, when applicable, notice of denied claims, denial reason(s) and appeal rights.	**All Products (excluding Pharmacy)**
10.	Verify enrollment and eligibility using Member information submitted by Employer and/or its authorized agent.	**All Products**
	Medical Only	
1.	CHLIC's standard enrollment forms are prepared and delivered to Employer for distribution to individuals eligible to enroll in the Plan.	**All Medical Products**
2.	CHLIC's standard ID card with toll-free telephone number are prepared and mailed directly to Members.	**All Medical Products**
3.	Administration of subrogation/conditional Claim Payment (terms described in Exhibit E).	**All Medical Products**
	Pharmacy Only	
1.	CHLIC's standard ID cards with toll-free telephone number are prepared and mailed directly to Members.	**All Pharmacy Products**
2.	Pharmacy claims are adjudicated typically on-line at time of service without access to information on other coverage, and therefore coordination of benefits (COB) for pharmacy claims does not occur. Claims for Plan Benefits will be paid regardless of coverage under another plan.	**All Pharmacy Products**
3.	CHLIC's standard drug utilization review services.	**All Pharmacy Products**
4.	CHLIC may receive and retain payments under contracts with drug manufacturers with respect to utilization covered under the Employer's medical benefit for the manufacturer's specialty drugs, which are drugs that typically are injected or infused and derived from living cells; target an underlying rare, chronic or costly condition; and/or require restricted access and/or close monitoring. If CHLIC enters into any such contracts, it does so on its own behalf, and not as agent of the Employer or the Plan.	**All Pharmacy Products**
	HEALTH SAVINGS ACCOUNT	
	Administration	
1.	Provision of Health Savings Account: CHLIC shall provide to Employer enrollment materials for Health Savings Accounts ("**HSA**") at a bank or other authorized entity with which CHLIC contracts (the "Bank Vendor") for Employer's employees enrolled in an eligible High Deductible Health Plan ("**HDHP**"). CHLIC and/or the Bank Vendor shall provide to Employer's eligible employees who open an HSA ("**HSA Account Holder**") telephonic and Internet customer service, debit cards, HSA checks (option made available to HSA account holders from the bank) to access HSA funds, required IRS forms such as the 1099 and 5498 and access to Individual Summary Statements that reflect account activity. CHLIC shall provide to Employer its standard reports of aggregate non-identifiable information concerning the administration of the HSA.	**HSA Product**
2.	Claim Forwarding: Each HSA Account Holder may elect to have claims not payable under the HDHP paid from funds in the Account Holder's HSA, to the extent that funds are available in such account ("**Claim Forwarding**"), whether or not the expense is a qualified IRS medical expense. Claim Forwarding is only available for payments due medical providers. Claim Forwarding is not available for pharmacy expenses.	**HSA Product**

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3.	Use of HSA: HSA Account Holders are solely responsible to use HSA funds as permitted by law, including Section 223(a) of the Internal Revenue Code, to qualify for applicable tax benefits.	**HSA Product**
4.	Enrollment in High Deductible Health Plan - Employer acknowledges that its prompt furnishing of complete and accurate HDHP eligibility and benefit information, including prompt depositing of contributions, is essential to the timely and efficient administration of its employees' health savings accounts and impacts bank ability to respond to employee account withdrawals or payments. It is understood that employee HDHP coverage terminations, including default terminations whether or not caused by employer failure to reconcile employee eligibility when so requested by CHLIC, could result in health savings account tax consequences for the employee and/or in interrupting the employee's eligibility to make health savings account contributions.	**HSA Product**
5	Access Codes. Employer shall ensure that each authorized user establishes an Access Code for access to the Online Portal. Employer shall further ensure that authorized users safeguard all Access Codes and shall be responsible for all use of Access Codes.	**HSA Product**
6	Online Portal. Access to the Online Employer Portal delivered by the Bank Account Administrator shall be in accordance with such manuals, training materials, terms of use, administrative control procedures, terms and conditions, and other information as shall be provided to Employer from time to time, and Employer shall ensure access to Online Employer Portal complies with any such information and materials. Employer's authorized users may be assigned different levels of access. Some of the functions that Employer may access on the Portal are: 1) view reserve funding account balance and activity; 2) fund up to 2000 participants using a CSV template; 3) perform manual funding of employee bank accounts; 4) download various reports; 5) learn of upcoming changes in HSA rules; 6) use the links and tools for HSA education and additional information.	**HSA Product**
7.	Employer agrees that any access, transaction, or business conducted using the Online Employer Portal is presumed by CHLIC to have been in compliance with HSA Plan Administration under Section 223(a) of the Internal Revenue Code. Any unauthorized use of the Online Employer Portal or any Access Code shall be solely the responsibility of the Employer.	**HSA Product**
	Employer Responsibilities	
1.	HSA Contributions - Employer will facilitate pre-tax payroll contributions by HSA Account Holders. Employer may elect to make its own contributions to HSA. Employer shall send HSA Account Holder contributions plus any Employer contributions directly to the Bank Vendor.	**HSA Product**
2.	Eligibility and Enrollment - Employer is responsible for distributing to eligible employees the HSA enrollment application and documents provided to Employer by CHLIC and the Bank Vendor. Employer will submit completed HSA enrollment applications to CHLIC and/or Bank Vendor, as indicated, in the established timeframe. It is understood and agreed that an eligible employee's HSA cannot be opened until the Bank Vendor has received all necessary documents and information and has determined the HSA can be established.	**HSA Product**

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3.	Information Verification - Employer shall verify information provided to CHLIC and Bank Vendor that is necessary for the establishment of the HSA. It is understood that the Bank Vendor shall rely on such information and verification in establishing and maintaining the HSA and in reporting required by law.	**HSA Product**
	Bank Vendor Relationship	
1.	Employee Agreement with Bank – Eligible employees wishing to enroll in an HSA may be required to execute certain bank documents including a custodial agreement. Approved eligible employees will become Account Holders and contract directly with the Bank Vendor for the establishment and maintenance of the HSA, including the issuance of debit cards and checks.	**HSA Product**
2.	Investment of Account Funds – While Bank Vendor offers various investment options in connection with the funds in the HSA, the HSA Account Holder is solely responsible for selecting and approving the investment vehicles into which their HSA funds will be invested. HSA Account Holders exercise sole investment discretion over their HSA investments.	**HSA Product**
3.	Bank Fees – CHLIC pays Bank Vendor to administer the HSA Accounts.	**HSA Product**
4.	Bank Fees to Accountholder – It is understood that there are separate account fees charged each HSA Account Holder by the Bank Vendor pursuant to terms communicated to HSA Account Holders through separate bank documents.	**HSA Product**
	Termination	
1.	Termination of HSA Account Holder's HDHP or of Services Under This Exhibit – Free Agents: In the event of the termination of an HSA Account Holder's HDHP coverage through CHLIC, the HSA Account Holder becomes a "**Free Agent**". Similarly, should CHLIC's HSA services under this Exhibit be terminated for any reason, either for a specific employee, or for the Employer as a whole, the affected HSA Account Holders shall from that point on be Free Agents. For Free Agents: (1) CHLIC shall no longer provide HSA services; (2) Any terms of this Exhibit shall no longer be applicable; (3) HSA shall continue to be maintained by the Bank Vendor directly not in its role as a contractor to CHLIC; (4) Bank Vendor shall issue new account numbers, debit cards, checks etc. to Free Agents; and (5) Bank Vendor shall inform Free Agents of the new applicable schedule of bank fees. Even if HSA Account Holders continue HDHP coverage through COBRA, they are still considered Free Agents for purposes of HSA services hereunder.	**HSA Product**
2.	Retroactive Terminations: It is understood and agreed that although this ASO Agreement contemplates instances in which an employee's HDHP coverage may be retroactively terminated, there will be no retroactive terminations with respect to HSA services provided hereunder. Termination of an employee's HDHP coverage or termination of an HSA shall result in the termination of services rendered under this Exhibit and the applicable fees, effective as of the end of the month that CHLIC receives notice of such termination.	**HSA Product**

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	Effect of HSA Plan on ASO Agreement Terms	
	All applicable provisions of the ASO Agreement apply to the HSA Services described in this Exhibit. In the event of a conflict between any provision of the ASO Agreement and the terms of the Exhibit with respect to the HSA services, the terms of this Exhibit shall govern.	**HSA Product**
	PLAN BOOKLET	
	Products excluding Health Savings Account	
	Prepare Member benefit booklet drafts to Employer.	**All Products**
	UNDERWRITING SERVICES	
1.	5500 Schedule C reporting.	**All Products**
2.	5500 Schedule A or Annual Reconciliation Disclosure reporting (when applicable)	**All Products**
3.	CHLIC's standard Underwriting services: a) benefit design analysis-b) projected cost analysis.	**All Products**
	HIPAA INDIVIDUAL RIGHTS	
	Products excluding Health Savings Account	
	Handling of requests from Members for access to, amendment and accounting of protected health information, and requests for restrictions and alternative communications as required under federal HIPAA law and regulations, as set out in this Agreement and its Exhibits.	**All Products**
	COST CONTAINMENT	
1.	Maximum reimbursable charge determinations of non-Participating Provider charges for covered services.	**All Medical Products (with out-of-network benefits)**
2.	CHLIC's standard cost containment controls: Application of non-duplication and coordination of benefits rules and coordination with Medicare.	**All Medical Products**
3.	Delivery of information, as necessary, regarding standard application of non-duplication or coordination of benefits.	**All Medical Products**
4.	Review of medical bills in accordance with CHLIC's then current Medical Bill Review program.	**All Medical Products**
5.	Network Savings Program, a national vendor network that provides discounted rates when a Member accesses care through a Network Savings Program contracted provider.	**All Medical Products**
6.	Annual reporting of CHLIC's standard cost containment results upon Employer's request.	**All Medical Products**
7.	Pharmacy Vendor Recoveries.	**All Pharmacy Products**

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	CUSTOMER REPORTING	
1.	Summary reports of medical and pharmacy cost and utilization experience are available through Cigna's web site, CignaAccess.com.	**All Medical and Pharmacy Products**
2.	CHLIC's standard pharmacy utilization reports.	**Pharmacy Product Only**
3.	Claim Reporting: CHLIC will provide standard banking and financial report information based upon paid claim data. CHLIC will not provide information on incurred-but-not reported claims, projected claims, pre-certifications of coverage, case management information or information on a Member's prognosis or course of treatment. Stop Loss Reporting is an optional service provided at an additional fee to Employers who have stop loss through another entity other than CHLIC. CHLIC will provide its standard reporting only after the stop loss carrier and Employer have executed CHLIC's standard Hold Harmless/Confidentiality Agreement.	**All Medical Products**
	MEMBER EXTERNAL REVIEW PROGRAM	
	CHLIC contracts with three (3) independent review organizations that meet the Patient Protection and Affordable Care Act (PPACA) external review requirements. Members may appeal eligible claims to an external independent review organization which is selected by CHLIC on a random basis. If Employer has chosen not to participate in this program, the Employer may be responsible for making other arrangements to meet the Patient Protection and Affordable Care Act (PPACA) external review requirements.	**All Medical Products**
	MEDICAL MANAGEMENT SERVICES	
	CHLIC provides integrated medical management that includes (depending upon the terms of the Plan) the following core services.	
1.	Pre-Admission Certification and Continued Stay Review (PAC/CSR) services to certify coverage of acute and sub-acute inpatient admissions/stays or provides guidance to appropriate alternative settings. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products**
2.	Case Management and Retrospective Review of Inpatient Care, a service designed to provide assistance to a Member who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support.	**All Medical Products**
3.	Assisting providers with resources and tools to enable them to develop long term treatment plans in the management of chronic or catastrophic cases.	**All Medical Products**
4.	The Cigna HealthCare Healthy Babies® Program is a one-time educational mailing which provides Participants with prenatal care education and resources to help them better manage their pregnancy. Other benefits of this program include Cigna Healthcare's 24-Hour Health Information Line℠ and pregnancy information on myCigna.com	**All Medical Products**
5.	HealthCare Cost and Quality tools on myCigna.com	**All Medical Products**

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6.	A panel of physicians and other clinicians to assess the safety and effectiveness of new and emerging medical technologies. The panel meets monthly to review and update coverage policies.	**All Medical Products**
7.	Cigna HealthCare's 24-Hour Health Information Line℠ is a service that provides 24 hour toll free access to nurses, who provide answers to healthcare questions, recommends appropriate settings for care and assists Participants in locating physicians. It also includes access to an extensive audio library on a wide range of medical topics.	**All Medical Products**
8.	Cigna LifeSOURCE Transplant Network® contracts with over seven hundred (700) transplant programs at more than one-hundred fifty (150) independent transplant facilities and provides access to solid organ and bone marrow/stem cell transplantation while improving cost containment and reducing financial risk.	**All Medical Products**
9.	A health education program that delivers mailings to Members with certain conditions.	**All Medical Products Except Comprehensive and Indemnity**
10.	If behavioral health services are provided/arranged by Cigna Behavioral Health (CBH), CBH provides utilization review and case management for both inpatient and outpatient, in-network behavioral health services.	**OAP and HSA OAP Products Only**
11.	Implementing clinical quality measurements, managing data, tracking and validating performance and initiating continuous quality improvement.	**All Medical Products Except Comprehensive and Indemnity**
12.	Transition of care services to allow Members with defined conditions to continue treatment with non-Participating Providers after enrollment for continued uninterrupted care for a limited time.	**All Medical Products Except Comprehensive and Indemnity**
13.	Focused utilization management of outpatient procedures and identification of appropriate alternatives. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products with PHS Plus**

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NETWORK MANAGEMENT SERVICES		
	CHLIC, and/or its affiliates shall:	
1.	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, fixed per person per period, per diem charges, incentive bonuses, case rates, withholds etc.). The amount and type of negotiated reimbursement may vary depending upon the type of plan. For example, a hospital may accept less for patients enrolled in certain types of plans than others;	**All Medical and Pharmacy Products**
2.	Credential and re-credential Participating Providers in accordance with CHLIC's credentialing requirements and ensure that third-party network vendors credential/re-credential Participating Providers in accordance with CHLIC's requirements;	**All Medical and Pharmacy Products**
3.	Monitor Participating Provider compliance with protocols and procedures for quality, Participant satisfaction, and grievance resolution;	**All Medical and Pharmacy Products**
4.	Facilitate the identification of Participating Providers by Members; and	**All Medical and Pharmacy Products**
5.	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Medical and Pharmacy Products**

ATTORNEYS' EYES ONLY

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

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ATTORNEYS' EYES ONLY

Client Name: [redacted]
Administrative Services Only Agreement

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

EFFECTIVE AUGUST 1, 2014

(Applicable to all Open Access Plus Products)

Department	CPT Code	Description	OAP Rate
All Departments	99213	OFFICE VISIT,EST EXP PROB FOC	$65.80
Adult Medicine	99396	WELL EXAM, EST, 40-64 YEARS	$102.94
Pediatrics	99392	WELL EXAM, EST, 1-4 YEARS	$85.77
Gastroenterology	45378	COLONOSCOPY - Professional Fee only, at a facility	$257.75
Neurology	64615	CHEMODENERVATION OF MUSCLE MIGRAINE	$157.18
Ophthalmology	66984	REMOVE CATARACT, INSERT LEN- Professional Fee only, at a facility	$700.01
Podiatry	11721	DEBRIDEMENT NAIL SIX OR MORE	$39.95
Radiology	71020	CHEST X-RAY, PA & LAT	$30.38
Radiology	G0202 + 77052	SCREENING MAMMOGRAPHY DIGITAL	$141.02
Urology	52000	CYSTOSCOPY	$253.87
General Surgery	47562	LAPAROSCOPY;CHOLECYSTECTOMY- Professional Fee only, at a facility	$837.79
Optometry	92014	EYE EXAM & TREATMENT	$109.35
Lab	80053	COMPREHENSIVE METABOLIC PANEL	$14.87
Lab	80061	LIPID PANEL	$18.85
ASC (Ambulatory surgical center) / Endoscopy Suite	Grouper 2		$469.00
ASC (Ambulatory surgical center) / Endoscopy Suite	Grouper 8		$1,104.00

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

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

The CMG CareToday (CMG low acuity clinics) visit rate is $59. Lab tests performed at the CMG CareToday facilities
are $10 per service. A complete list of rates for CMG CareToday services is available on request.

CMG pharmacy rates (30-day supply):
Brand Name: AWP – 10.56% + $2.75 dispensing fee
Generic: AWP – 35% + $2.75 dispensing fee

Exhibit C – Claim Audit Agreement (Sample)

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

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

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

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

1. Audit Specifications

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

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

2. Review of Specifications

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

3. Access to Information

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

4. Audit Report

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

5. Comment on Audit Report

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

Client Name: [redacted]
Administrative Services Only Agreement

6. Confidentiality

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

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

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

7. Restricted Use of the Audit Information

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

8. Termination

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

Cigna Health and Life Insurance Company

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date: _____

Employer: _____

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date: _____

Auditor: _____

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date: _____

Client Name: [redacted]
Administrative Services Only Agreement

Exhibit D – Privacy Addendum

("Business Associate Agreement")

I. GENERAL PROVISIONS

Section 1. Effect. As of the Effective Date, the terms and provisions of this Addendum are incorporated in and shall supersede any conflicting or inconsistent terms and provisions of (as applicable) the Administrative Services Only Agreement and/or Flexible Spending Account or Reimbursement Accounts Administrative Services Agreement to which this Addendum 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 Addendum sets out terms and provisions relating to the use and disclosure of Protected Health Information ("**PHI**") without written authorization from the Individual. To the extent there is a conflict between the Agreement and this Addendum, this Addendum shall control.

Section 2. Amendment to Comply with Law. CHLIC, on behalf of itself and its affiliates and subsidiaries that perform services under the Agreement (collectively referred to as **"CHLIC"**), Employer (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 Addendum to the extent necessary to allow either the Plan or CHLIC to comply with applicable laws and regulations including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160 to 164) ("**HIPAA Privacy and Security Rules**").

Section 3. Relationship of Parties. The parties intend that CHLIC is an independent contractor and not an agent of the Plan.

II. PERMITTED USES AND DISCLOSURES BY CHLIC

Section 1. Uses and Disclosures Generally. Except as otherwise provided in this Addendum, CHLIC 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. CHLIC shall not further use or disclose PHI other than as permitted or required by this Addendum, or as required by law.

Section 2. To Carry Out Plan Obligations. To the extent CHLIC is to carry out one or more of the Plan's obligations under Subpart E of 45 C.F.R. Part 164, CHLIC agrees to comply with the requirements of Subpart E that apply to the Plan in the performance of such obligations.

Section 3. Management and Administration.

(A) CHLIC may use PHI for the proper management and administration of CHLIC or to carry out the legal responsibilities of CHLIC.

(B) CHLIC may disclose PHI for the proper management and administration of CHLIC, provided that disclosures are: (a) required by law; or (b) CHLIC 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 CHLIC of any instances of which it is aware in which the confidentiality of the information has been breached.

(C) CHLIC may use or disclose PHI to provide Data Aggregation services relating to the Health Care Operations of the Plan, or to de-identify PHI. Once information is de-identified, this Addendum shall not apply.

Section 4. Required or Permitted By Law. CHLIC may use or disclose PHI as required or permitted by law.

III. OTHER OBLIGATIONS AND ACTIVITIES OF CHLIC

Section 1. Receiving Remuneration in Exchange for PHI Prohibited. CHLIC 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. CHLIC 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 Addendum. CHLIC shall determine what constitutes the minimum necessary to accomplish the intended purpose of such disclosure.

Section 3. Security Standards. CHLIC shall use appropriate safeguards and comply with Subpart C of 45 C.F.R. 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, CHLIC shall:

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

(B) Ensure that any agent or subcontractor to whom CHLIC provides Electronic PHI agrees to implement reasonable and appropriate safeguards to protect such information; and,

(C) CHLIC shall promptly report to the Plan any Security Incident with respect to Electronic PHI of which it becomes aware and which has compromised the protections set forth in the HIPAA Security Rule. In the event of a Security Incident, CHLIC shall report to the Plan in writing (i) any actual, successful Security Incident within ten (10) business days of the date on which CHLIC first becomes aware of such actual, successful Security Incident and (ii) to the extent commercially reasonable, the Plan may request CHLIC to report in writing attempted but unsuccessful Security Incidents involving PHI of which CHLIC becomes aware, provided however that such reports are not required for trivial and routine incidents such as port scans, attempts to log-in with an invalid password or user name, denial of service attacks that do not result in a server being taken off-line, malware and pings or other similar types of events.

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

Section 6. Security Breach Notification. CHLIC 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 (10) business days after CHLIC'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 CHLIC 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, CHLIC is not the agent of the Plan or the Employer (as "agent" is defined under common law). CHLIC 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, CHLIC 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). CHLIC will pay the costs of issuing notices required by law and other remediation and mitigation which, in CHLIC's discretion, are appropriate and necessary to address the Breach. CHLIC will not be required to issue notifications that are not mandated by applicable law. CHLIC 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 45 C.F.R. §164.408(c).

Section 7. Disclosures to and Agreements with Third Parties. CHLIC agrees to ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of CHLIC agree to the same restrictions, conditions and requirements that apply to CHLIC with respect to such information.

Section 8. Access to PHI. CHLIC 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 time and manner required in 45 C.F.R. §164.524.

Section 9. Availability of PHI for Amendment. CHLIC shall respond to a request by an Individual for amendment to such Individual's PHI contained in a Designated Record Set in the time and manner required in 45 C.F.R. §164.526.

Section 10. Right to Confidential Communications and to Request Restriction of Disclosures of PHI. CHLIC shall respond to a request by an Individual for confidential communications or to restrict the uses and disclosures of PHI contained in such Individual's Designated Record Set in the time and manner required by 45 C.F.R. §164.522. CHLIC shall not be obligated to agree to, or implement, any restriction, if such restriction would hinder Health Care Operations or the provision of the functions,

activities or services, unless such restriction would otherwise be required by 45 C.F.R. § 164.522(a).

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

Section 12. Availability of Books and Records. CHLIC 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 CHLIC on behalf of the Plan, available to the Secretary for purposes of determining the Plan's compliance with the Privacy Rule.

Section 13. Standard Transactions. CHLIC certifies that it conducts any applicable transactions that are subject to the HIPAA standard transaction rules (45 C.F.R. Parts 160-164) as required under such rules.

IV. TERMINATION OF AGREEMENT WITH CHLIC

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 CHLIC in the event that CHLIC materially breaches any obligation of this Addendum 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 CHLIC 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 Addendum, CHLIC 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, CHLIC may terminate the Agreement at the end of such period.

Section 2. Use and Disclosure of PHI upon Termination. The parties hereto agree that it is not feasible for CHLIC to return or destroy PHI at termination of the Agreement; therefore, the protections of this Addendum for PHI shall survive termination of the Agreement, and CHLIC 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. OBLIGATIONS OF THE PLAN AND PLAN SPONSOR

Section 1. Disclosures Generally. Except as otherwise provided for in this Addendum, the Plan will not request that CHLIC use or disclose PHI in any manner that would not be permissible under HIPAA or HITECH if done by the Plan.

Section 2. Disclosures to the Plan or Third Parties. To the extent the Plan requests that CHLIC disclose PHI either to the Plan or to a third party acting for the Plan, the Plan represents and warrants that:

(A) It only will request PHI for the purposes of Treatment, Payment, or Health Care Operations, or another permitted purpose under the HIPAA Privacy Rule;

(B) The information requested is the minimum necessary to achieve the purpose of the disclosure; and

(C) If the PHI is to be disclosed to a third party, the Plan has a business associate agreement in place with the third party, where required.

Section 3. Disclosure to Plan Sponsor. To the extent the Plan requests that CHLIC to disclose PHI to the Plan Sponsor, the Plan and Plan Sponsor each represent and warrant that:

(A) The information only will be used for one of the following purposes:

i. Plan Administration functions, as defined by the HIPAA Privacy Rule, and that the Plan Sponsor has executed the required plan amendment and certification allowing the disclosure, as set out in the HIPAA Privacy Rule;

ii. Enrollment functions, provided the information to be disclosed is limited to enrollment and disenrollment information; or

iii. To amend, modify, or terminate the Plan, or to obtain premium bids to provide health insurance coverage under the Plan, provided the information to be disclosed is limited to Summary Health Information, as defined in the HIPAA Privacy Rule; and

(B) The information requested is the minimum necessary to achieve the purpose of the disclosure.

VI. DEFINITIONS FOR USE IN THIS ADDENDUM

Definitions. Certain capitalized terms used in this Addendum 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 Addendum 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 Addendum 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 Protected Health Information 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 CHLIC 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 CHLIC; any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by CHLIC 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 CHLIC.

"Covered Entity" means the 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 CHLIC for the Plan, or used, in whole or in part, by CHLIC

or the Plan to make decisions about Individuals.

"Effective Date" shall mean the effective date of the Agreement.

"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 45 C.F.R. §164.514(e)(2).

"Protected Health Information" or **"PHI"** shall have the same meaning as set forth at 45 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.

Exhibit E – Conditional Claim/Subrogation Recovery Services

I. Plans Without CHLIC General Stop Loss Coverage

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

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

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

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

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

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

Name:
Title:
Address:
Telephone:

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

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

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

Client Name: [redacted]
Administrative Services Only Agreement

II. Plans with CHLIC Stop Loss Coverage

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

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

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

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

ADDENDUM A
TO
ADMINISTRATIVE SERVICES AGREEMENT
BETWEEN

[redacted] AND
CIGNA HEALTH AND LIFE INSURANCE COMPANY

AND
EMPLOYER: [redacted]

PART A
BASIC SERVICES PROVIDED BY
[redacted]

I. BASIC SERVICES

A. PROVIDER NETWORK

(i) [redacted] shall make available a network of providers in Massachusetts and Rhode Island ("Provider Network") consisting of providers under contract, either directly with [redacted] or through Intermediaries ("Network Providers"), to deliver Plan services to Participants. Network Providers shall be compensated for Health Care Costs (as defined below) at rates set forth in contracts governing the provision of Plan services. Employer acknowledges that [redacted] negotiates contracts with Network Providers and Intermediaries ("Provider Agreements"), and that the continued participation of any particular Network Provider is based upon many factors, including but not limited to the ability of [redacted] and the Network Provider or Intermediary to reach mutual agreement on contract renewal terms, Network Provider's continuing satisfaction of applicable credentialing standards, and personal decisions such as a Network Provider's retirement or decision to move out of the service area. Network Providers may also, at any time, limit member access to their practice based upon lawful criteria and close or open their panels.

(ii) [redacted] and/or Network Providers may be unable to provide services due to circumstances beyond their control, including but not limited to a major disaster, epidemic, strike, war, terrorist act, civil insurrection, the complete or partial destruction of facilities, riot, or natural disaster. In such case, [redacted] will make a good faith effort to provide administrative services according to this Addendum, and to arrange for the provision of Plan services to Participants to the extent practical and according to [redacted] best judgment. [redacted] will incur no liability or obligation for delay or failure to meet its obligations if the failure or delay is caused by such an event.

(iii) [redacted] does not provide health care services; rather [redacted] arranges for health care through contracts with Intermediaries and Network Providers for Network Providers to provide health care services. Neither Intermediaries nor Network Providers are the employees, agents or representatives of [redacted] for any purposes and [redacted] is not responsible for their acts, omissions, representations or other conduct.

B. Health Care Costs

Health Care Costs paid to Network Providers consist of payments:

(i) made to providers, Participants, and Intermediaries (defined as organizations of providers, provider networks, and vendors);

(ii) which may be in the form of any of the following: (i) fee for service payments; (ii) fixed per person per period payments for designated services, provided, however, Employer acknowledges that prepayment of fixed per person per period charges to providers or Intermediaries for designated services does not relieve Employer's funding obligations for those designated services in the event Participants receive those services from providers not participating in the fixed per person per period reimbursement arrangement or in the event of nonperformance by providers reimbursed on a fixed per person per period basis or Intermediaries due to insolvency or otherwise; (iii) payments based upon risk sharing compensation methodologies including but not limited to DRGs, case rates, and withholds and settlements based upon achievement of aggregate performance targets; and (iv) flat fees or contingent payments based upon, for example, percentage of savings; and

(iii) which are for or related to Plan services, including but not limited to (a) claims for Plan services; (b) payments for health care cost management services provided, such as specialty case management programs; and (c) payments related to provider participation in the Provider Network, such as network access fees to Intermediaries;

C. Claim Re-pricing Services and Network Savings Fee

In connection with making available to Plan participants access to its Network Providers in Massachusetts and Rhode Island, [redacted] shall receive a fee for re-pricing claims from its Network Providers to reflect the appropriate rate of reimbursement under the terms of the [redacted] Provider Agreements. [redacted] shall receive either a per claim network savings fee for each re-priced claim or a per employee per month network access fee for each covered employee of Employer residing in Massachusetts and Rhode Island.

Client Name: [redacted]
Administrative Services Only Agreement

PART B
BUSINESS ASSOCIATE ADDENDUM

1. **DEFINITIONS**. Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the Rules.

   1.1. The following terms used in this Addendum shall have the same meaning as those terms in the HIPAA Rules:

Breach	Individual	Secretary
Data Aggregation	Minimum Necessary	Security Incident
Designated Record Set	Notice of Privacy Practices	Subcontractor
Disclosure	Protected Health Information	Unsecured PHI
Health Care Operations	Required By Law	Use

   1.2. Subcontractor. "Subcontractor" includes both direct and indirect subcontractors (e.g., any subcontractor of a subcontractor).

   1.3. "HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164, as amended from time to time.

2. **OBLIGATIONS OF [redacted] WITH RESPECT TO PROTECTED HEALTH INFORMATION**

   2.1. [redacted] agrees not to use or disclose Protected Health Information (PHI) other than (i) as necessary to perform the Services set forth in the ASA; (ii) as permitted or required by this Addendum; or (iii) as Required by Law.

   2.2. [redacted] agrees to 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 herein.

   2.3. [redacted] agrees to mitigate, to the extent practicable, any harmful effect that is known to [redacted] of a use or disclosure of PHI by [redacted] in violation of the requirements of this Addendum.

   2.4. Tufts HP agrees to report to Covered Entity any use or disclosure of the PHI not provided for by this Addendum of which it becomes aware, including breaches of unsecured PHI, and any Security Incident of which [redacted] becomes aware. In determining how and how often [redacted] shall report to Covered Entity in writing the Security Incidents required above, both Covered Entity and Tufts HP agree that incidents such as unsuccessful attempts at unauthorized access and system interference occur frequently and that there is no benefit to data security from requiring the specific documentation and reporting of such unsuccessful Security Incidents. Consequently, both Covered Entity and [redacted] agree that this section 2.4 shall constitute the documentation, notice and written report of such unsuccessful attempts at unauthorized access or system interference and that no further notice or report of such attempts will be required. By way of example (and not limitation in any way), the parties consider the following to be illustrative (but not exhaustive) of Unsuccessful Security Incidents when they do not result in unauthorized access, use, or disclosure of electronic PHI or interference with an information system: pings and other broadcast attacks on a firewall, port scans, unsuccessful log-on attempts, denial of service attacks, and any combination of the above.

2.5. [redacted] shall ensure that in accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, any subcontractors or agents that create, receive, maintain, or transmit PHI on behalf of its vendors that are Business Associates of [redacted] agree in writing to the same restrictions, conditions, and requirements that apply to the vendor with respect to such information.

2.6. Within the time and in the manner prescribed by 45 C.F.R. § 164.524, [redacted] agrees to provide access as required under 45 C.F.R. § 164.524 to Individuals, following the Individual's request, to any PHI that is solely in [redacted] possession, including rights to inspect and obtain copies of PHI for so long as the PHI is maintained.

2.7. [redacted] agrees to respond to requests for amendments to PHI in a Designated Record Set requested by an Individual pursuant to 45 C.F.R. § 164.526 within the time and in the manner prescribed by 45 C.F.R. § 164.526.

2.8. [redacted] agrees to make its internal practices, books and records, including policies relating to the use and disclosure of PHI received from, or created or received by [redacted] on behalf of, Covered Entity available to the Secretary of Health and Human Services within a reasonable amount of time following the request, for the purposes of the Secretary determining Covered Entity's compliance with the HIPAA Rules. This provision shall survive termination of this Addendum.

2.9. [redacted] agrees to document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

2.10. [redacted] agrees to provide an Individual who has requested an accounting of disclosures in accordance with 45 C.F.R. § 164.528 information collected in accordance with Section 2.9 of this Addendum, within the time and in the manner prescribed by 45 C.F.R. § 164.528.

3. PERMITTED USES AND DISCLOSURES

3.1. Except as otherwise limited by this Addendum, [redacted] may use or disclose PHI on behalf of, or to provide services to, Covered Entity in order to perform Services as agreed upon by [redacted] and Covered Entity, if such use or disclosure of PHI would not violate the Privacy Rule if done by Covered Entity.

3.2. [redacted] may use the PHI for the proper management and administration of [redacted] and to carry out the present and/or future legal and/or contractual responsibilities of [redacted]

3.3. Tufts HP may disclose the PHI to third parties for the proper management and administration of [redacted] provided that the disclosures are Required By Law, as defined by 45 C.F.R. § 164.501, or [redacted] obtains reasonable assurances in writing from the third party that the same restrictions, conditions, and requirements that apply to the [redacted] with respect to such information also apply to such third party.

3.4. [redacted] may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

3.5. [redacted] may provide PHI to appropriate Federal and State authorities, when permitted by applicable law or when Required by Law.

3.6. [redacted] may disclose PHI to Plan Sponsor for Plan Administration Purposes. [redacted] can rely on Covered Entity's determination that such request is for only the minimum necessary data as required by the HIPAA Rules,45 CFR 64.502(b).

3.7. Upon the request of the Covered Entity, [redacted] may disclose the PHI in its possession to a Business Associate of the Covered Entity, as defined in 45 C.F.R. § 160.103. Covered Entity will ensure that if Covered Entity and/or such Business Associate requests such disclosure of PHI, the request shall be only for the minimum necessary PHI as required by the HIPAA Rules, 45 CFR 64.502(b) and that [redacted] can rely on Covered Entity's and/or the Business Associate's determination that such request is for only the minimum necessary data.

3.8. [redacted] may release Summary Health Information, as defined in 45 C.F.R. § 164.504(a), for the purposes of obtaining premium bids to provide health insurance coverage under the group health plan or for modifying, amending or terminating the group health plan.

3.9. [redacted] may de-identify any and all PHI provided that the de-identification conforms to the requirements of 45 C.F.R. § 164.514(b).

3.10. Limited Data Sets - [redacted] may use any and all PHI to create a limited data set, provided that the limited data set conforms to the requirements of 45 CFR 164.514(e)(2). [redacted] may use or disclose such limited data set for the purposes set forth in 45 CFR 164.514(e)(3). Prior to any disclosure [redacted] shall enter into a data use agreement, that conforms to the requirements of 45 CFR 164.514(e)(4), with the recipient of the limited data set.

4. **OBLIGATIONS OF COVERED ENTITY WITH RESPECT TO PROTECTED HEALTH INFORMATION**.

4.1. Covered Entity shall notify [redacted] of any limitation(s) in its notice of privacy practices in accordance with 45 C.F.R. § 164.520, prior to distributing such notice, to the extent that such limitation may affect [redacted] use or disclosure of PHI. [redacted] shall promptly notify Covered Entity if it cannot comply with the proposed limitation. If [redacted] so notifies Covered Entity, both parties agree to make good faith efforts to develop a mutually agreeable limitation.

4.2. Covered Entity shall notify [redacted] of any changes in, or revocation of, authorization by an Individual to use or disclose PHI, to the extent that such changes may affect [redacted] use or disclosure of PHI.

4.3. Covered Entity shall notify [redacted] of any restrictions to the use or disclosure of PHI that Covered Entity has been requested to agree to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect [redacted] use or disclosure of PHI. [redacted] shall promptly notify Covered Entity if it cannot comply with the proposed restriction. If [redacted] so notifies Covered Entity, Covered Entity shall not agree to such restriction.

4.4. Covered Entity shall not request, and shall prohibit Plan Sponsor from requesting [redacted] to use or disclose PHI in any manner that would not be permissible under the HIPAA Rules if done by Covered Entity, except for uses and disclosures of PHI for data aggregation or management and administrative activities of [redacted]

4.5. Covered Entity represents and warrants that the Plan Sponsor to whom [redacted] has been requested to release PHI, pursuant to Section 3.6 of this Addendum, has amended Plan Documents and provided Covered Entity with certification pursuant to 45 C.F.R. § 164.504(f)(2). Covered Entity further represents and warrants that Covered Entity and Plan Sponsor will use PHI solely for legitimate plan administration purposes and will not use PHI for any decisions affecting an employee's employment status.

4.6. Covered Entity agrees to immediately notify [redacted] of any changes in its Business Associates to whom [redacted] has been requested to release PHI pursuant to Section 3.7 of this Addendum. Covered Entity further represents and warrants that it has entered into binding Business Associate Contracts that conform to the requirements of 45 C.F.R. § 164.504(e) with any and all Business Associates to whom [redacted] is requested to release PHI and also represents and warrants that any such request is only for the minimum necessary data as that term is defined in 45 CFR § 164.502(b) as amended from time to time.

4.7. Covered Entity represents and warrants that when required by the HIPAA Rules, it will obtain valid authorization from Individuals prior to requesting PHI from [redacted] Covered Entity further represents and warrants that it will require its Business Associates to whom [redacted] has been directed to release PHI pursuant to Section 3.7 of this Addendum, to obtain valid authorization from Individuals prior to requesting PHI from [redacted]

4.8. Covered Entity represents and warrants that if Covered Entity or another Business Associate of Covered Entity requests that PHI be provided to Covered Entity, Plan Sponsor or another Business Associate of Covered Entity, the request shall be only for the minimum necessary PHI as required by the HIPAA Rules, 45 CFR 64.502(b) and that [redacted] can rely on Covered Entity's and/or the Business Associate's determination that such request is for only the minimum necessary data.

5. TERM AND TERMINATION.

5.1. **Term.** The term of this Addendum shall begin on the Effective Date and continue for successive one year terms until terminated as provided herein. Termination of the ASA shall also terminate this Addendum. Notwithstanding the forgoing, if [redacted] provides run-out services after the termination of the ASA to provide Services, this Addendum shall remain in effect during the run-out period.

5.2. **Termination for Cause**. Upon either party's knowledge of a material breach of this Addendum by the other, the non-breaching party shall either: (1) notify the breaching party of the breach; in the event that the breach is not cured within thirty (30) calendar days after written notice describing the breach is received by the breaching party, either party may terminate this Addendum; or (2) immediately terminate this Addendum if cure is not possible.

5.3. **Effect of Termination.** Upon termination of this Addendum for any reason,

(a) [redacted] shall, if feasible, at [redacted] option, either return or destroy PHI received from Covered Entity, or created or received by [redacted] on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of [redacted] shall retain no copies of the returned or destroyed PHI.

(b) Covered Entity acknowledges that it will not be feasible for [redacted] to return or destroy all PHI. [redacted] hereby notifies Covered Entity that it is not feasible to return or destroy any and all documentation required to be maintained by applicable law or regulation and/or [redacted] internal policies and procedures.

(c) [redacted] agrees to notify Covered Entity of any other conditions that make return or destruction infeasible.

[redacted] shall extend the protections of this Addendum to any PHI not returned or destroyed and agrees to limit further uses and disclosures of such PHI to those purposes that make return or destruction infeasible, for so long as [redacted] maintains such PHI. This provision shall survive termination of this Addendum.

Client Name: [redacted]
Administrative Services Only Agreement

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6. **INTEGRATION WITH THE AGREEMENT TO PROVIDE SERVICES**. This Addendum shall be and hereby is incorporated into any agreement to provide Services now existing or subsequently established. The terms, agreements and obligations of the parties set forth herein shall be in addition to and shall supplement the terms, agreements and obligations of the parties. In the event of any inconsistencies, the terms and conditions of this Addendum shall prevail.

7. **INDEMNIFICATION**. Each party shall indemnify and hold harmless the other, its agents, officers and employees (in their capacity of employees of Sponsor and/or [redacted] and not as Members of the health benefits plan) from all damages, losses, obligations, liabilities, claims, costs and expenses (including reasonable attorney fees, penalties, and fines) incurred by the indemnified party, its agents, officers and employees incident to any threatened or actual claim, demand, suit, penalty, investigation or action that relates to or arises out of the indemnifying party's negligence, fraud or criminal conduct in the performance of this Addendum.

8. **COMPLIANCE WITH LAW**. Both parties agree to comply with all applicable state and federal privacy and data protection laws, including the HIPAA Rules.

9. **RELATIONSHIP OF PARTIES**. Each party is and shall be construed an independent contractor, and no party shall be deemed to be the agent or partner or joint venturer with the other, nor have any relationship as a result of this Addendum other than as independent contractors.

10. **SEVERABILITY**. If any provision of this Addendum is unenforceable, invalid or violates applicable law, such provision shall be deemed stricken and shall not affect the enforceability of any other provisions of this Addendum.

11. **AMENDMENT**. This Addendum may only be amended or modified by written agreement of both parties. The parties agree to take such action as is necessary to amend this Addendum from time to time as is necessary to comply with the requirements of the HIPAA Rules and applicable privacy and data security laws.

12. **INTERPRETATION**. Any ambiguity in this Addendum shall be resolved to permit compliance with the HIPAA Rules.

EXHIBIT E

Administrative Services Only Agreement

By and Between

[redacted]

"Employer"

And

Cigna Health and Life Insurance Company
"CHLIC"

And

[redacted]

Effective Date: January 1, 2016

EXCEPT AS PROVIDED BY APPLICABLE LAW, THIS AGREEMENT AND ITS TERMS ARE PROPRIETARY AND CANNOT BE DISCLOSED WITHOUT THE PERMISSION OF EACH OF THE PARTIES

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Client Name: [redacted]
Administrative Services Only Agreement

THIS AGREEMENT, effective January 1, 2016 (the "**Effective Date**") is by and between [redacted] ("**Employer**") and Cigna Health and Life Insurance Company ("**CHLIC**") and [redacted]

RECITALS:

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

WHEREAS, Employer has requested CHLIC and [redacted] to furnish certain administration services in connection with the Plan 3207740.

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

Definitions

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

Applicable Law – means the state, federal and international laws and regulations that apply. Applicable Law includes but is not limited to the Employee Retirement Income Security Act of 1974, as amended and the rules and regulations thereunder ("**ERISA**"), the Health Insurance Portability and Accountability Act of 1996, as amended and the rules and regulations thereunder ("**HIPAA**"), the Foreign Corrupt Practices Act ("**FCPA**") and any other anti-bribery or anti-corruption laws in the countries where the Parties conduct business.

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

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

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

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

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

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

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

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

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

Run-Out Claims – claims for Plan Benefits relating to health care services and products that are incurred prior to termination of this Agreement; termination of a Plan benefit option or termination of eligible Members, as applicable.

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

Client Name: [redacted]
Administrative Services Only Agreement

Section 1. Term and Termination of Agreement

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

i. The date which is at least sixty (60) days from the date that either Employer or CHLIC provides written notice to the other of termination of this Agreement;

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

iii. The date upon which Employer fails to fund the Bank Account as required by this Agreement or fails to pay CHLIC any charges identified in this Agreement when due provided CHLIC notifies Employer of its election to terminate;

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

v. Notwithstanding the foregoing, all provisions in this Agreement reasonably related to CHLIC's administration of the Plan's Pharmacy Benefit (as such term is defined in the Schedule of Financial Charges) (the "Pharmacy Benefit Provisions"), shall continue in effect for no less than thirty-six (36) months commencing on the Effective Date, except that, if any of the following dates occurs, the Pharmacy Benefit Provisions will cease being in effect as of such date:

   a. The effective date of any Applicable Law or governmental action which prohibits performance of the activities in connection with the Pharmacy Benefit required by this Agreement;

   b. The date upon which Employer fails to fund the Bank Account as required by this Agreement for claims under the Pharmacy Benefit or fails to pay CHLIC any charges in connection with the Pharmacy Benefit identified in this Agreement when due, provided CHLIC notifies Employer of its election to terminate the Pharmacy Benefit Provisions; or

   c. The date that is sixty (60) days after notice by either Employer or CHLIC ("non-defaulting party") of the material breach by the other (the "defaulting party") of a material obligation of the defaulting party related to the Pharmacy Benefit (other than failure to fund the Bank Account or failure to pay any charges when due pursuant to Section 1.v.b above) that is not cured to the reasonable satisfaction of the non-defaulting party within a reasonable time following the initial notice of breach.

During such thirty-six (36) month period (or shorter period, as applicable under (a), (b) or (c) above), CHLIC will continue to be the exclusive provider of Pharmacy Benefit administration services for the Plan's Pharmacy Benefit.

In the event that Employer purports to terminate such arrangement or enters into an agreement with another pharmacy benefit manager ("PBM") or other third party to provide any or all pharmacy benefit management services for Employer's benefit plan prior to the end of such thirty-six (36) month period, then, within thirty (30) days of CHLIC's written request, Employer shall pay CHLIC the amount of $1.25 per the average monthly number of Members who were enrolled in the Plan's Pharmacy Benefit from the beginning the thirty-six (36) month period to the effective date of such purported termination or other agreement multiplied by the number of months remaining until the end of the thirty-six (36) month period. However, if Employer terminates its CHLIC medical coverage under this Agreement, no such fee shall apply.

Client Name: [redacted]
Administrative Services Only Agreement

Section 2. Claim Administration and Additional Services

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

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

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

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

Section 3. Funding and Payment of Claims

a. Employer shall establish a Bank Account, and maintain in the Bank Account an amount sufficient at all times to fund checks written on it for the following (collectively "**Bank Account Payments**"): (i) Plan Benefits; (ii) those charges and fees identified in the Schedule of Financial Charges as payable through the Bank Account and (iii) any sales or use taxes, or any similar benefit- or Plan-related charge or assessment however denominated, which may be imposed by any governmental authority. Bank Account Payments may include without limitation: (i) fixed per person payments and pay-for-performance incentive payments to Participating Providers; (ii) amounts owed to CHLIC; and (iii) amounts paid to CHLIC's affiliates and/or subcontractors for, among other things, network access or in- and out-of network health care services/products provided to Members. CHLIC may credit the Bank Account with payments due Employer under a stop loss policy issued by CHLIC or an affiliate.

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

c. In the event that sufficient funds are not available in the Bank Account to pay all Bank Account Payments when due, CHLIC shall cease to process claims for Plan Benefits including Run-Out Claims.

d. CHLIC will promptly adjust any underpayment of Plan Benefits by drawing additional funds due the claimant from the Bank Account. In the event CHLIC overpays a claim for Plan Benefits or pays Plan Benefits to the wrong party, it shall take all reasonable steps to recover the overpayments. CHLIC shall not be required to initiate court, mediation, arbitration or other administrative proceedings to recover any overpayment. However, when it elects to do so, CHLIC is expressly authorized by Employer to take all actions on behalf of the Employer and/or the Plan to pursue overpayment recovery, including, but not limited to, retaining counsel, settling and compromising claims, in which case CHLIC shall be responsible for the attorney fees, court costs or arbitration fees incurred by CHLIC in the specific overpayment recovery action (not applicable to subrogation or conditional claim payment recoveries), but not any other associated third party costs absent consent of CHLIC. CHLIC shall not be responsible for reimbursing any unrecovered payments of Plan Benefits unless made as a result of its gross negligence or intentional wrongdoing.

e. Employer shall promptly reimburse CHLIC for any Bank Account Payments paid by CHLIC with its own funds on Employer's behalf and no such payment by CHLIC shall be construed as an assumption of any of Employer's liability.

f. Following termination of this Agreement, Employer shall remain liable for payment of all due Bank Account Payments and for all reimbursements due Members under the Plan.

This Section 3 shall survive termination of this Agreement.

Section 4. Charges

a. Charges. CHLIC shall provide to Employer a monthly statement of all charges Employer is obligated to pay under this Agreement that are not paid as Bank Account Payments. Payment of all billed charges shall be due on the first day of the month, as indicated on the monthly statement. Payments received after the last day of the month in which they are due, shall be subject to late payment charges, from the due date at a rate calculated as follows: the one (1) year Treasury constant maturities rate for the first week ending in January plus five percent (5%). For purposes of calculating late payment charges, payments received will be applied first to the oldest outstanding amount due. CHLIC may reasonably revise the methodology for calculating late payment charges upon thirty (30) days' advance written notice to Employer.

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

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

This Section 4 shall survive termination of this Agreement.

Client Name: [redacted]
Administrative Services Only Agreement

Section 5. Enrollment and Determination of Eligibility

a. Eligibility Determinations and Information. Employer is responsible for administering Plan enrollment. In determining any person's right to benefits under the Plan, CHLIC shall rely upon enrollment and eligibility information provided by the Employer. Such information shall identify the effective date of eligibility and the termination date of eligibility and shall be provided promptly to CHLIC in a format and with such other information as reasonably may be required by CHLIC for the proper administration of the Plan.

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

c. Reconciliation of Eligibility and Information and Default Terminations. CHLIC will periodically share potential discrepancies in eligibility information with Employer. Employer will review and reconcile any discrepancies within thirty (30) days of receipt. If Employer fails to timely do so, CHLIC may terminate coverage for any Member not listed as eligible in Employer's submitted eligibility information.

Section 6. Claim Audits and Confidentiality

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

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

ii. If Employer has five thousand (5,000) or more employees who are Members, Employer may conduct one such audit every Plan Year (but not within six (6) months of a prior audit); otherwise, Employer may conduct one such audit every two (2) Plan Years (but not within eighteen (18) months of a prior audit).

iii. Auditor will review payment documents (subject to any contrary terms in Participating Provider agreements) 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. 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.

b. Confidentiality

i. Subject to the requirements of Applicable Law, the terms of this Agreement and the Privacy Addendum in Exhibit D, a signed Business Associate agreement between Employer and its designee, and a signed Confidentiality Agreement between CHLIC and applicable designee; CHLIC shall release copies of confidential claims and Plan Benefit payment information in CHLIC's claims system ("**Confidential Information**") and may release copies of proprietary information relating to the Plan in CHLIC's claims system ("**Proprietary**

Information") to the Employer and/or its designees. Employer agrees that Employer and its designees will keep Confidential Information and Proprietary Information confidential and will use Confidential Information and Proprietary Information solely for the purpose of administering the Plan or as otherwise required by law. Employer is solely responsible for the consequences of any use, misuse, or disclosure of Confidential Information provided by CHLIC pursuant to this paragraph b.

ii. CHLIC will maintain the confidentiality of all Protected Health Information in its possession in accordance with the Privacy Addendum in Exhibit D 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.

c. Upon termination of this Agreement and subject to the provisions of Section 6.b above, CHLIC shall make information available, to the extent administratively feasible, if the Parties agree upon the charge to be paid by Employer.

The obligations set forth in this Section 6 (b), shall survive termination of this Agreement.

Section 7. Plan Benefit Liability

a. Employer Liability for Plan Benefits. Employer is responsible for all Plan Benefits including any Plan Benefits paid as a result of any legal action. Employer is responsible for reimbursing CHLIC and [redacted] its directors, officers and employees for any reasonable expense incurred (including reasonable attorneys' fees) by them in the defense of any action or proceeding involving a claim for Plan Benefits. CHLIC and [redacted] shall reasonably cooperate with Employer, in its defense of such actions.

If Employer directs CHLIC in writing to pay a claim for Extra-Contractual Benefits, Employer is responsible for funding the payment and such payments shall not be considered in determining reimbursements or payments under stop loss insurance or in determining any risk-sharing or performance guarantee reimbursements. Employer shall reimburse CHLIC and [redacted] for any liability or expenses (including reasonable attorneys' fees) CHLIC or [redacted] may incur in connection with making such payments.

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

c. Alternative Litigation Management Option. Prior to the beginning of each Plan Year, and contingent upon timely payment by Employer of the associated additional "Claim Litigation Charge" set forth in the Schedule of Financial Charges, Employer may elect to have CHLIC assume responsibility for the management of any claim-related legal action and bear the legal expenses associated with defending such action so long as CHLIC processed the claim(s) in dispute. This option does not extend to actions against Employer and/or CHLIC related to the payment of Extra-Contractual Benefits. Each Party will provide notice to the other of any action and will fully cooperate in the defense of the action unless a potential conflict of interest exists. Nothing in this paragraph (c) shall be read to contravene the explicit terms of 7(a) and 7(b). Employer shall remain responsible for payment of any benefits determined due under the Plan and any damages or penalties assessed in connection with the action.

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

Section 8. Modification of Plan and Charges

a. CHLIC shall have the right to revise the charges identified in this Agreement (i) on the first anniversary of this Agreement and at any time thereafter by giving Employer at least sixty (60) days' prior written notice, but not more frequently than once in a twelve (12) month period, (ii) upon any modification or amendment of the benefits under the Plan, (iii) upon any variation of fifteen percent (15%) or more in the number of Members used by CHLIC to calculate its charges under this Agreement, and/or (iv) upon any change in law or regulation that materially impacts CHLIC's liabilities and/or responsibilities under this Agreement.

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

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

Section 9. Modification of Agreement

This Agreement constitutes the entire contract between the Parties regarding the subject matter herein. Except, as otherwise provided herein, the provisions of this Agreement shall control in the event of a conflict with the terms of any other agreements. No modification or amendment hereto shall be valid unless in writing and signed by an authorized person of each of the Parties, except that modification of charges pursuant to Section 8 above may be made by written notice to Employer by CHLIC. If Employer pays such revised charges or fails to object to such revision in writing within fifteen (15) days of receipt, this Agreement shall be deemed modified to reflect the charges as communicated by CHLIC.

Section 10. Laws Governing Agreement

a. This Agreement shall be construed in accordance with the laws of the State of Connecticut without regard to conflict of law rules, and both Employer and CHLIC consent to the venue and jurisdiction of its courts.

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

Section 11. Information in CHLIC and [redacted] Processing Systems

CHLIC and [redacted] may retain and use all Plan-related claim and Plan Benefit payment information recorded for or otherwise integrated into CHLIC's and [redacted] business records including claim processing systems during the ordinary course of business (provided, however, that claim or payment information will be available to Employer pursuant to Section 6). CHLIC and [redacted] will retain claim and payment information as required by Applicable Law.

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Section 12. Resolution of Disputes

It is understood and agreed that any dispute between the Parties arising from or relating to the performance or interpretation of this Agreement ("**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 initiate Executive Review by giving the other Party written notice of the Controversy and shall specifically request Executive Review of said Controversy in such notice. Within twenty (20) calendar days of any Party's written request for Executive Review, the receiving Party shall submit a written response. Both the notice and response shall include a statement of each Party's position and a summary of the evidence and arguments supporting its position. Within thirty (30) calendar days of any Party's request for Executive Review, an executive level employee of each Party shall be designated by the Party to meet and confer with his/her counterpart to attempt to resolve the dispute. Each representative shall have full authority to resolve the dispute.

b. In the event that a Controversy has not been resolved within thirty-five (35) calendar days of the request of Executive Review under Section 12.a, above, the disputing Party shall initiate mediation by providing written notice to the other Party, which shall be conducted in Hartford, Connecticut, in accordance with the American Arbitration Association Commercial Mediation Rules ("**Mediation**"). Each Party shall assume its own costs and attorneys' fees, and the compensation and expenses of the mediator and any administrative fees or costs associated with the mediation proceeding shall be borne equally by the Parties.

c. In the event that a Controversy has not been resolved by Executive Review or Mediation, the Controversy shall be settled exclusively by binding arbitration. The arbitration shall be conducted in the same location as noted in Section 12.b. above, in accordance with the American Arbitration Association Commercial Arbitration Rules, and which to the extent of the subject matter of the arbitration, shall be binding not only on all Parties to this Agreement but on any other entity controlled by, in control of or under common control with the Party to the extent that such affiliate joins in the arbitration, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Each Party shall assume its own costs and attorneys' fees, and the compensation and expenses of the arbitrator and any administrative fees or costs associated with the arbitration proceeding shall be borne equally by the Parties. The decision of the arbitrator shall be final, conclusive and binding, and no action at law or in equity may be instituted by any Party other than to enforce the award of the arbitrator.

d. The Parties intend this dispute resolution procedure described above to be a private undertaking and agree that an arbitration conducted under this provision will not be consolidated with an arbitration involving other plans administered in whole or in part by CHLIC or [redacted] or other Cigna Corporation or [redacted] affiliate, or third parties not parties to this Agreement. The arbitrator will be without power to conduct arbitration on a class or representative basis. The Employer waives its right to participate in a class action or representative proceeding against CHLIC or [redacted] or other Cigna Corporation or [redacted] The arbitrator may award declaratory or injunctive relief only in favor of the individual party seeking relief and only to the extent necessary to provide relief warranted by that party's individual claim. All issues are for the arbitrator to decide, except the courts will decide those issues relating to the scope and enforceability of the arbitration provision.

This Section 12 shall survive termination of this Agreement.

Section 13. Third Party Beneficiaries

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

Section 14. Waivers

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

Section 15. Headings

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

Section 16. Severability

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

Section 17. Force Majeure

CHLIC and/or [redacted] shall not be liable for any failure to meet any of the obligations required under this Agreement where such failure to perform is due to any contingency beyond the reasonable control of CHLIC and/or [redacted] their employees, officers, or directors. Such contingencies include, but are not limited to, acts or omissions of any person or entity not employed or reasonably controlled by CHLIC and/or [redacted] their employees, officers, or directors, acts of God, fires, wars, accidents, labor disputes or shortages, and governmental laws, ordinances, rules or regulations.

Section 18. Assignment and Subcontracting

No Party may assign any right, interest, or obligation hereunder without the express written consent of the other Party; provided, however that CHLIC and [redacted] may assign any right, interest, or responsibility under this Agreement to its affiliates and/or subcontract specific obligations under this Agreement provided that CHLIC or [redacted] shall not be relieved of its obligations under this Agreement when doing so.

Client Name: [redacted]
Administrative Services Only Agreement

Section 19. Notices

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

To CHLIC:
Cigna Health and Life Insurance Company
401 Chestnut Street
Chattanooga, TN 37402
Attention: Michael Cate, Underwriting Director

To [redacted]

With a copy to:
[redacted]

To Employer:
[redacted]

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

Section 20. Identifying Information and Internet Usage

Except, as necessary in the performance of their duties under this Agreement, no Party may use the other's name, logo, service marks, trademarks or other identifying information or to establish a link to the other's World Wide Web site without its prior written approval.

Client Name: [redacted]
Administrative Services Only Agreement

SIGNATURES

IN WITNESS WHEREOF, the Parties have caused this Agreement, to be executed in triplicate and signed by their respective officers duly authorized to do so as of the dates given below. Employer executes as the authorized representative of the Plan with respect to the Privacy Addendum and the [redacted] Addendum to this Agreement.

Dated at _____, _____ [redacted]

This _____ day of _____, _____

By: _____
Name:
Its
Duly Authorized

Dated at Hartford, Connecticut

CIGNA HEALTH AND LIFE INSURANCE COMPANY

This 14th day of December, 2016

By: _____
Name: Victoria A. Sirica
Its Contractual Agreement Unit Manager
Duly Authorized

Dated at _____, _____ [redacted]

This _____ day of _____, _____

By: _____
Name:
Its
Duly Authorized

Schedule of Financial Charges

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

	MEDICAL/DENTAL ADMINISTRATION CHARGES (Includes Benefit Advisor Fees payments agreed to by Employer)	
Product	**Description**	**Charge**
Medical	• Open Access Plus (OAP) with PHS Plus Medical Management	**$55.05/employee/month**
Medical	• Benefit Advisor Fees	**$34.05/employee/month Included in Medical Administration Charge**
Dental	• Dental Preferred Provider Organization (DPPO)	**$6.25/employee/month**
Dental	• Benefit Advisor Fees	**$2.50/employee/month Included in Dental Administration Charge**
MEDICAL/DENTAL NETWORK ACCESS FEE, UTILIZATION MANAGEMENT FEE AND OPTIONAL PROGRAM FEE		
Product	**Description**	**Charge**
Medical	• OAP Access Fee	**$17.75/employee/month**
Dental	• DPPO Access Fee	**$0.70/employee/month Included in Dental Administration Charge**

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	MULTI-YEAR CHARGE/FEE GUARANTEES	
	The maximum increase for the Medical Administration Charge(s) and Network Access Fee(s) for the 2017 Plan Year will be 0.00% over the 2016 Plan Year charges/fees. The maximum increase for the Medical Administration Charge(s) and Network Access Fee(s) for the 2018 Plan Year will be 3.00% over the 2017 Plan Year charges/fees. The above fee guarantees are not applicable to Pharmacy Administration Fee. The above charges/fees are guaranteed for the time periods identified above, provided, however, that CHLIC may revise the above charges/fees pursuant to Section 8 of this Agreement.	
AMOUNTS OWED TO CHLIC		
Amounts paid by CHLIC with its own funds on behalf of Employer or the Plan with respect to charges for which Employer or the Plan is obligated to pay under this Agreement including Plan Benefits, Bank Account Payments (including fix per person payments and pay-for-performance payments to Participating Providers), governmental taxes or assessments.		

ATTORNEYS' EYES ONLY

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	CIGNA PHARMACY BENEFIT MANAGEMENT SERVICES CHARGES AND RELATED PROVISIONS	

Definitions

- "Average Wholesale Price" or "AWP" is the Average Wholesale Price for a given pharmaceutical product in effect on the dispense date for the actual package size dispensed as published by Medi-Span or other alternative publication or benchmark reasonably designated by CHLIC.
- "Brand Drug Claim" is a claim for pharmaceutical product that is adjudicated as a brand drug as indicated on the claim record generated by the claim processing system used by CHLIC. For application of discounts and dispensing fees, a "Brand Drug Claim" excludes a claim for a generic drug within its exclusivity period or other period of limited competition, as CHLIC reasonably determines under its standard policies. Except if and where the language expressly states otherwise, a Brand Drug Claim does not include a Specialty Brand Drug Claim.
- "Dispensing Fee" means an amount paid to a pharmacy for providing professional services necessary to dispense medication to a Member.
- "Drug Claim" is a claim for a pharmaceutical product.
- "Generic Drug Claim" is a claim for a pharmaceutical product that is adjudicated as a generic drug as indicated on the claim record generated by the claim processing system used by CHLIC. For application of discounts and dispensing fees, a "Generic Drug Claim" includes a claim for a generic drug within its exclusivity period or other period of limited competition, as CHLIC reasonably determines under its standard policies. Except if and where the language expressly states otherwise, a Generic Drug Claim does not include a Specialty Generic Drug Claim.
- "Mail", when immediately preceding the term "Brand Drug Claim," "Generic Drug Claim," "Specialty Drug Claim," "Specialty Brand Drug Claim, or "Specialty Generic Drug Claim" means that the resulting term (e.g., "Mail Brand Drug Claim") refers to such claim as dispensed by a Mail Service Pharmacy.
- "Mail Service Pharmacy" or "Cigna Tel-Drug" or "Cigna Home Delivery Pharmacy" is a pharmacy that is owned or operated by Connecticut General or an affiliated company(ies) (currently, Tel-Drug, Inc. and Tel-Drug of Pennsylvania, LLC), which dispenses drugs covered under the Plan's Pharmacy Benefit by mail, and is not a Retail Pharmacy.
- "Maximum Allowable Charge" means the list of drugs designated from lists established by CHLIC for which reimbursement to a pharmacy shall be paid according to the MAC price established by CHLIC for such list.
- "Pharmacy Benefit" means the terms of the Plan that govern coverage and care/utilization management of drugs and related supplies dispensed to Members and charged to the Plan by the Mail Service Pharmacy or Retail Pharmacies through CHLIC's pharmacy claim processing system.
- "Rebates" or "Manufacturer Formulary Payments" means amounts that CHLIC collects under contracts with drug manufacturers that are based on utilization of certain of the manufacturers' brand drugs under the Plan's Pharmacy Benefit and the drug's status on the Cigna drug formulary.

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- "Retail", when immediately preceding the term "Brand Drug Claim," "Generic Drug Claim," "Specialty Drug Claim," "Specialty Brand Drug Claim, or "Specialty Generic Drug Claim" means that the resulting term (e.g., "Retail Brand Drug Claim") refers to such claim as dispensed by a Retail Pharmacy.
- "Retail Pharmacy" is a pharmacy that is entitled to payment under the Plan for drugs it dispenses that are covered under the Plan's Pharmacy Benefit, and is not a Mail Service Pharmacy.
- "Specialty Drug Claim" is a claim for a pharmaceutical product that is reasonably determined by CHLIC to be a specialty drug in accordance with industry practice. Specialty drugs generally are (i) injected or infused and derived from living cells, or are oral non-protein compounds (e.g., oral chemotherapy drugs); (ii) target the underlying condition, which is usually one of a relatively rare, chronic and costly nature; and/or (iii) require restricted access and/or close monitoring.
- "Specialty Brand Drug Claim" means a claim for a pharmaceutical product that is adjudicated, as indicated on the claim record generated by the claim processing system used by CHLIC, as a brand drug which is also a specialty drug.
- "Specialty Generic Drug Claim" means a claim for a pharmaceutical product that is adjudicated, as indicated on the claim record generated by the claim processing system used by CHLIC, as a generic drug which is also a specialty drug.

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PHARMACY ADMINISTRATION FEE
• Cigna Pharmacy Product Administration Fee: $1.39/per script
CHARGES FOR DRUGS COVERED UNDER THE PLAN'S PHARMACY BENEFIT
Drugs Dispensed by Mail Service Pharmacy: CHLIC will charge Employer the following for claims covered under the Plan's Pharmacy Benefit and dispensed by the Mail Service Pharmacy, subject to the "Drug Charges – Additional Provisions" section:
Brand Drug Claims: AWP minus an average discount of 25.50%. **Generic Drug Claims:** The drug's charge on a CHLIC generic Maximum Allowable Charge schedule that generates an annual average aggregate discount across Generic Drug Claims dispensed at Cigna Home Delivery Pharmacy to CHLIC group-client book of business of AWP minus 86.50%. **Specialty Drug Claims**: The drug's charge discounted as shown in the Cigna Home Delivery Pharmacy Specialty Drug List, attached as Appendix A hereto. **Home Delivery Drug Claims:** An average dispensing fee of no more than $9.79.
Drugs Dispensed by Retail Pharmacies: CHLIC will charge Employer the following for drugs covered under the Plan's Pharmacy Benefit and dispensed by a Retail Pharmacy to the Plan Members, subject to the "Drug Charges – Additional Provisions" section:
Retail Brand Drug Claims: The lesser of (i) AWP minus an average discount of 16.50%; or (ii) the Retail Pharmacy's usual and customary charge. **Retail Generic Drug Claims** (other than those to which the above brand discount applies): The lesser of: (i) the drug's charge on a CHLIC generic Maximum Allowable Charge schedule that generates an annual average aggregate discount across Generic Drug Claims dispensed at Retail Pharmacies to CHLIC group-client book of business of AWP minus 75.93% (Plan-specific results may vary based on drug mix); or (ii) the Retail Pharmacy's usual and customary charge. **Retail Specialty Generic Drug Claims:** The drug's charge discounted as shown in the Specialty Drug List, attached as Appendix A hereto. **Retail Specialty Brand Drug Claims:** The lesser of (i) AWP minus an annual average aggregate discount of 15.80%; or (ii) the Retail Pharmacy's usual and customary charge. **Retail Drug Claims:** An average dispensing fee of no more than $1.30, except in the case of usual and customary claims, for which no dispensing fee is charged.

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DRUG CHARGES – ADDITIONAL PROVISIONS
• Cigna Home Delivery Pharmacy's discounts are applied to the manufacturer average wholesale price (AWP) for the dispensed size (or to the AWP for the manufacturer-packaged quantity closest to the dispensed size, if there is no AWP for the dispensed size).
• The amount paid to the Retail Pharmacy for Brand, Generic, or Specialty Drug Claims may or may not be equal to the amount charged to Employer, and CHLIC will absorb or retain any difference.
• An excess achieved in any Plan-specific discount floor or dispensing fee cap offered under this Agreement will be used to offset a shortfall in any other Plan-specific discount floor or dispensing fee cap offered under this Agreement.
• Industry Changes to or Replacement of Average Wholesale Price (AWP). Notwithstanding any other provision in this Agreement, including in this Exhibit, in the event of any major change in market conditions affecting the pharmaceutical or pharmacy benefit management market, including, for example, any change in the markup, methodologies, processes or algorithms underlying the published AWP(s), CHLIC may adjust any or all of the charges, rates, discounts, guarantees and/or fees in connection with CHLIC's administration of the Plan's Pharmacy Benefit hereunder, including any that are based on AWP, as it reasonably deems necessary to preserve the economic value or benefit of this Agreement as it existed immediately prior to such change. Additionally, and notwithstanding any other provision in this Agreement, including in this Exhibit, CHLIC may replace AWP as its pharmaceutical pricing benchmark with an alternative benchmark and/or may replace Medi-Span, or other such publication as its source for the AWP or alternative benchmark with a different pricing source, provided that CHLIC adjusts any or all such AWP-Based Charges or such alternative benchmark-based charges as it reasonably deems necessary to preserve the economic value or benefit of this Agreement as it existed immediately prior to such replacement or immediately prior to the event(s) giving rise to such replacement, as the case may be.

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DRUG MANUFACTURER-PAYMENT SHARING
Subject to the caveats below, CHLIC will remit to Employer the following portion of Rebates that CHLIC collects with respect to utilization under the Plan's Pharmacy Benefit: The greater of 100.00% of Rebates on such utilization dispensed in the full calendar year immediately preceding CHLIC's remittance, or the sum of $32.39 multiplied by the number of Retail Pharmacy Brand Drug Claims plus $175.76 multiplied by the number of Mail Service Pharmacy Brand Drug Claims dispensed in such full calendar year.
Caveats: (1) Upon termination of this Agreement, CHLIC may apply Rebates otherwise payable to offset Bank Account or other deficits of charges identified in this Agreement. (2) Should Employer terminate this Agreement before completion of the then-current Plan Year, no Rebates shall be due with respect to that Plan Year as Rebates are based on completion of an entire Plan Year. (3) All applicable caveats communicated in writing by CHLIC in connection with its proposal made in connection with this Agreement are hereby incorporated by reference. (4) For percentage-based sharing arrangements, payout amount may differ slightly from the stated percentage when payout occurs before manufacturers' final reconciliations and payments are made to CHLIC. (5) Rebates are not paid out on Run-Out Claims or on claims for drugs covered under the federal 340B drug pricing program. (6) CHLIC or its agent contracts with drug manufacturers on CHLIC's own behalf, and not as agent of the Employer or the Plan. Timing of Rebate Pay-Out: Remittance will be provided within ninety (90) days after the close of each applicable calendar year for the portion of such calendar year that coincides with the Plan Year.
AUDIT RIGHTS RELATED TO MANUFACTURER PAYMENTS
Employer's third party auditor may audit records directly related to CHLIC's performance of its obligations hereunder regarding sharing of manufacturer formulary payments (a/k/a "rebates") once in each twelve-month period upon the following conditions: Employer shall provide at least forty-five (45) days written notice to CHLIC; the auditor (including its individual auditors conducting the audit) shall be agreeable to Employer and CHLIC; a mutually agreed upon non-disclosure/non-use contract shall be executed by Employer, the auditor and CHLIC; the records to be audited shall be no more than two years old as of the date of the audit; the scope of records to be audited shall be as mutually agreed upon by Employer's third party auditor and CHLIC as those which are necessary to determine compliance with the rebate-sharing obligations under this Agreement; the audit shall be conducted at a mutually acceptable time during regular business hours at CHLIC's office where such records are located; records shall not be removed or photocopied without CHLIC's express written consent; the auditor shall provide its audit report to CHLIC and Employer at the same time; and the auditor may disclose the aggregate amount of manufacturer formulary payments due Employer but no other details of CHLIC's manufacturer contracts of which the auditor is apprised, if any.

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FEES FOR PROCESSING RUN-OUT CLAIMS		
OAP and DPPO	Run-Out Period of twelve (12) months CHLIC shall not be required to process Run-Out Claims until it has received full payment of the required fees.	**The sum of the last four (4) months of billed fees applicable to the terminated (i) Agreement, (ii) Plan benefit option or (iii) Members.**
Pharmacy	Run-Out Period of three (3) months for all pharmacy claims CHLIC shall not be required to process Run-Out Claims until it has received full payment of the required fees.	**The sum of the last three (3) months of billed fees applicable to the terminated (i) Agreement, (ii) Plan benefit option or (iii) Members.**
SUBROGATION		
	Subrogation/Conditional Claim Payment. Identification, investigation and recovery of claim payments involving other party liability or where another entity is responsible for payment (including by way of example but not by limitation automobile insurance, homeowner insurance, commercial property insurance, worker's compensation). (This service is only provided with respect to Medical coverage).	**5% of recovery plus litigation costs if counsel is retained and an appearance is filed on behalf of CHLIC or Employer in any litigation, or a lawsuit is filed on their behalf;** **29% of recovery if no counsel is retained and in all other instances, including cases where state law requires that employee benefit plans be named as party defendants or involuntary plaintiffs.**

ATTORNEYS' EYES ONLY

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CHLIC COST CONTAINMENT FEES

CHLIC, a Cigna company, administers the following programs to contain costs with respect to charges for health care service/supplies that are covered by the Plan. In administering these programs, CHLIC contracts with vendors to perform program related services. Specific vendor fees are available upon request. CHLIC's charge for administering these programs is the percentage (indicated below) of either (1) the "net savings" (i.e. the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings, less the applicable vendor fee which generally ranges from 7-11% of the program savings) or (2) the "gross savings" (i.e. the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings; CHLIC pays the applicable vendor fee) or (3) the "recovery" (i.e. the amount recovered) as applicable.

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

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

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

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

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

b. the provider's billed charge.

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

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ATTORNEYS' EYES ONLY

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

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7.	Provider Credit Balance Recovery Program	**29% of recovery**
8.	High Cost Specialty Pharmaceutical Audits	**29% of recovery**
9.	Pharmacy Vendor Recoveries	**30% of recovery**
10.	Class Action Recoveries	**35% of recovery**
	DENTAL COST CONTAINMENT	
	Dental Cost Containment	**25% of gross savings**
	CARE MANAGEMENT/COST CONTAINMENT PROGRAM FEES	
	CHLIC arranges for third parties to provide care management services to: (i) contain the cost of specified health care services/items overall with respect to all plans insured and/or administered by CHLIC, and/or (ii) improve adherence to evidence based guidelines designed to promote patient safety and efficient patient care.	**Specific vendor fees and care management program services are available upon request.**
	ELIGIBILITY OVERPAYMENT RECOVERY FEES	
	Eligibility Overpayment Recovery Vendor Services. Identification and recovery of funds in situations where the overpayment is due to the late receipt of Member termination information. (This service is only provided with respect to Medical coverage).	**29% of recovery**
	EXTERNAL REVIEW AND CONSULTATIVE REVIEW FEES	
	When a Member elects an External Review (as that term is defined in ERISA) of a benefit determination by an independent third party, the cost of a specific third party review is dependent on the nature and complexity of the issue on appeal. In highly complex, non-routine cases or cases related to new technology or experimental-investigational treatment, as part of the internal appeal process a panel of reviewers may be necessary. Third party review charges will be commensurate with the number of reviewers (usually only one is used), as well as their level of expertise and time required to complete the review.	**$500-$4,000 Review**
	STRATEGIC ALLIANCES	
	CHLIC contracts directly or indirectly with other managed care entities and third party network vendors for access to their provider networks and discounts. These third parties charge either a network access fee, which is included in CHLIC's monthly charges, or a percentage of the savings realized on a claim by claim basis as a result of the application of their discounts. Charges based on percentage of savings may be paid from the Bank Account. Additional details regarding specific charges will be provided upon request.	**All Medical Products**

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

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ADDITIONAL SERVICES		
Service	**Description**	**Charge**
Behavioral Health	Behavioral Care Advocacy provides behavioral health services in which claims are funded on a fee-for-service basis. It includes focused utilization review and case management for both inpatient and outpatient, in-network behavioral health services. This payment arrangement is with respect to the CA/NC Member population only.	**Included in Medical Access Fee**
Pharmacy Clinical Program	**Step Therapy Program** – a prior authorization/step therapy program that encourages cost-effective clinically appropriate drug utilization and reduces costs by creating a sequence of "steps" in the choice of medication used to treat some common medical conditions.	**Included in Pharmacy Administration Charge**
Clinical Program	**Cigna TheraCare® Program** – a targeted condition drug therapy management program that targets individuals using specialty medications for certain chronic conditions and helps them better understand their condition, medication side effects and importance of adherence.	**Included at No Additional Cost**
Your Health First	A proactive health education and improvement program for Members with a chronic condition. The program involves services that span across the Member's health needs. Behavioral coaching principles and evidence based medicine guidelines are utilized to optimize self-management skills and foster sustained health improvements. The program targets a chronic population at high risk for near term and future high cost medical expenses. Members are identified as having a chronic condition through a variety of sources which may include: claims data, referrals, and self-identification. A variety of resources is provided to those with a chronic condition, including access to online tools, personalized support, and targeted materials. The program includes the following components for those with a chronic condition: • Chronic condition-specific coaching • Pre- and post-discharge calls • Lifestyle management coaching: stress, weight management and tobacco cessation • Treatment decision support and coaching In order to continuously assess the effectiveness of the program and/or test new ideas to further engage Members around their health, a small sample of Members may be placed in a comparison group which for a defined period of time receives alternative services or is suppressed from receiving proactive outreach, such as engagement letters and/or calls. This could affect a few Members targeted for outreach during this limited time period.	**For OAP Products: Included in Medical Access Fee**

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Claim Litigation	Claim Litigation Services	**$1,000/employee/month**
	Client Fund	
Wellness Fund	For clinical/wellness/behavioral programs offered by CHLIC that are purchased, CHLIC will establish a Wellness Fund in the amount of $35,000.00. This fund will be used to defray the cost of CHLIC designated and arranged health and wellness improvement programs (e.g. biometric screenings, flu shots) for employees of Employer and to reward participation in these programs. The Wellness Fund is a one-time credit to be used from 01/01/2016-12/31/2016. Unused funds cannot be rolled over and CHLIC must pre-approve use of the Wellness Fund. The Wellness Fund shall be extinguished upon termination of this Agreement and any fund amount not used prior to termination of this Agreement shall only be available to Employer for the purpose of funding the cost of those reimbursable services provided prior to such termination.	

ATTORNEYS' EYES ONLY

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Client Name: [redacted]
Administrative Services Only Agreement

Exhibit A - Plan Booklet

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

Exhibit B – Services

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

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8.	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Products**
9.	Member Explanation of Benefit ("EOB") statements including, when applicable, notice of denied claims, denial reason(s) and appeal rights.	**All Products (excluding Pharmacy)**
10.	Verify enrollment and eligibility using Member information submitted by Employer and/or its authorized agent.	**All Products**
	Medical Only	
1.	CHLIC's generic enrollment form is made available to Employer for individuals eligible to enroll in the Plan.	**All Medical Products**
2.	CHLIC's standard ID card with toll-free telephone number are prepared and mailed directly to Members.	**All Medical Products**
3.	Administration of subrogation/conditional Claim Payment (terms described in Exhibit E).	**All Medical Products**
	Dental Only	
1.	CHLIC's generic enrollment form is made available to Employer for individuals eligible to enroll in the Plan.	**All Dental Products**
2.	CHLIC's generic ID cards are prepared and bulk shipped to the employer's address to distribute to their employees.	**All Dental Products**
3.	Standard Dental predetermination of benefits for dental procedures on a voluntary basis.	**All Dental Products**
4.	When elected, the Cigna Oral Health Integration Program® (OHIP) includes the provision of administrative services necessary to provide eligible Members with certain health conditions enhanced dental benefits. The program covers the following conditions: Maternity, Diabetes, Cardiovascular Programs, cerebrovascular disease (stroke), chronic kidney disease, organ transplants and head/neck cancer radiation, and is aimed at improving overall health by encouraging Members to obtain needed dental treatment by providing enhanced benefits. As appropriate, OHIP may be expanded to include new procedures, conditions and programs in the future.	**All Dental Products**
	Pharmacy Only	
1.	CHLIC's standard ID cards with toll-free telephone number are prepared and mailed directly to Members.	**All Pharmacy Products**
2.	Pharmacy claims are adjudicated typically on-line at time of service without access to information on other coverage, and therefore coordination of benefits (COB) for pharmacy claims does not occur. Claims for Plan Benefits will be paid regardless of coverage under another plan.	**All Pharmacy Products**
3.	CHLIC's standard drug utilization review services.	**All Pharmacy Products**
4.	CHLIC may receive and retain payments under contracts with drug manufacturers with respect to utilization covered under the Employer's medical benefit for the manufacturer's specialty drugs, which are drugs that typically are injected or infused and derived from living cells; target an underlying rare, chronic or costly condition; and/or require restricted access and/or close monitoring. If CHLIC enters into any such contracts, it does so on its own behalf, and not as agent of the Employer or the Plan.	**All Pharmacy Products**

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PLAN BOOKLET		
Products excluding Health Savings Account		
	Prepare and make accessible Member benefit booklet drafts to Employer.	**All Products**
UNDERWRITING SERVICES		
1.	5500 Schedule C reporting.	**All Products**
2.	5500 Schedule A or Annual Reconciliation Disclosure reporting (when applicable)	**All Products**
3.	CHLIC's standard Underwriting services: a) benefit design analysis-b) projected cost analysis.	**All Products**
HIPAA INDIVIDUAL RIGHTS		
Products excluding Health Savings Account		
	Handling of requests from Members for access to, amendment and accounting of protected health information, and requests for restrictions and alternative communications as required under federal HIPAA law and regulations, as set out in this Agreement and its Exhibits.	**All Products**
COST CONTAINMENT		
1.	Maximum reimbursable charge determinations of non-Participating Provider charges for covered services.	**All Medical Products (with out-of-network benefits)**
2.	CHLIC's standard cost containment controls: Application of non-duplication and coordination of benefits rules and coordination with Medicare.	**All Medical Products**
3.	Delivery of information, as necessary, regarding standard application of non-duplication or coordination of benefits.	**All Medical and Dental Products**
4.	Review of medical bills in accordance with CHLIC's then current Medical Bill Review program.	**All Medical Products**
5.	Dental Cost Containment, a network of additional participating PPO providers that provide discounts for which CHLIC retains a portion of the savings generated.	**All Dental Products**
6.	Network Savings Program, a national vendor network that provides discounted rates when a Member accesses care through a Network Savings Program contracted provider.	**All Medical Products**
7.	Annual reporting of CHLIC's standard cost containment results upon Employer's request.	**All Medical and Dental Products**
8.	Pharmacy Vendor Recoveries.	**All Pharmacy Products**

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	CUSTOMER REPORTING	
1.	Summary reports of medical, dental and pharmacy cost and utilization experience are available through Cigna's web site, CignaAccess.com.	**All Medical, Dental and Pharmacy Products**
2.	CHLIC's standard pharmacy utilization reports.	**Pharmacy Product Only**
3.	Claim Reporting: CHLIC will provide standard banking and financial report information based upon paid claim data. CHLIC will not provide information on incurred-but-not reported claims, projected claims, pre-certifications of coverage, case management information or information on a Member's prognosis or course of treatment. Stop Loss Reporting is an optional service provided at an additional fee to Employers who have stop loss through another entity other than CHLIC. CHLIC will provide its standard reporting only after the stop loss carrier and Employer have executed CHLIC's standard Hold Harmless/Confidentiality Agreement.	**All Medical Products**
	MEMBER EXTERNAL REVIEW PROGRAM	
	CHLIC contracts with three (3) independent review organizations that meet the Patient Protection and Affordable Care Act (PPACA) external review requirements. Members may appeal eligible claims to an external independent review organization which is selected by CHLIC on a random basis. If Employer has chosen not to participate in this program, the Employer may be responsible for making other arrangements to meet the Patient Protection and Affordable Care Act (PPACA) external review requirements.	**All Medical Products**
	MEDICAL MANAGEMENT SERVICES	
	CHLIC provides integrated medical management that includes (depending upon the terms of the Plan) the following core services.	
1.	Pre-Admission Certification and Continued Stay Review (PAC/CSR) services to certify coverage of acute and sub-acute inpatient admissions/stays or provides guidance to appropriate alternative settings. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products**
2.	Case Management and Retrospective Review of Inpatient Care, a service designed to provide assistance to a Member who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support.	**All Medical Products**
3.	Assist providers with resources and tools to enable them to develop long term treatment plans in the management of chronic or catastrophic cases.	**All Medical Products**
4.	The Cigna HealthCare Healthy Babies® Program is a one-time educational mailing which provides Participants with prenatal care education and resources to help them better manage their pregnancy. Other benefits of this program include the 24-Hour Health Information Line℠ and pregnancy information on myCigna.com.	**All Medical Products**
5.	HealthCare Cost and Quality tools on myCigna.com	**All Medical Products**
6.	A panel of physicians and other clinicians to assess the safety and effectiveness of new and emerging medical technologies. The panel meets monthly to review and update coverage policies.	**All Medical Products**

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7.	The 24-Hour Health Information Line℠ is a service that provides twenty-four (24) hour toll free access to nurses, who provide answers to healthcare questions, recommend appropriate settings for care and assist Participants in locating physicians. It also includes access to an extensive audio library on a wide range of medical topics.	**All Medical Products**
8.	Cigna LifeSOURCE Transplant Network® contracts with over seven hundred fifty (750) transplant programs at more than one-hundred sixty (160) independent transplant facilities and provides access to solid organ and bone marrow/stem cell transplantation while improving cost containment and reducing financial risk.	**All Medical Products**
9.	A health education program that delivers mailings to Members with certain conditions.	**All Medical Products Except Comprehensive and Indemnity**
10.	If behavioral health services are provided/arranged by Cigna Behavioral Health (CBH), CBH provides utilization review and case management for both inpatient and outpatient, in-network behavioral health services.	**OAP Products Only**
11.	Implement clinical quality measurements, track and validate performance and initiate continuous quality improvement.	**All Medical Products Except Comprehensive and Indemnity**
12.	Transition of care services to allow Members with defined conditions to continue treatment with non-Participating Providers after enrollment for continued uninterrupted care for a limited time.	**All Medical Products Except Comprehensive and Indemnity**
13.	Focused utilization management of outpatient procedures and identification of appropriate alternatives. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products with PHS Plus**
	NETWORK MANAGEMENT SERVICES	
	CHLIC, and/or its affiliates or contracted vendors shall:	
1.	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, fixed per person per period, per diem charges, incentive bonuses, case rates, withholds etc.). The amount and type of negotiated reimbursement may vary depending upon the type of plan. For example, a hospital may accept less for patients enrolled in certain types of plans than others; In addition, CHLIC may contract with Participating Providers and other parties for performance-based incentive payments to promote quality of care, patient safety and cost efficiency.	**All Medical and Pharmacy Products**
2.	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, fixed per person per period, per diem charges, incentive bonuses, case rates, withholds etc.). In addition, CHLIC may contract with Participating Providers and other parties for performance-based incentive payments to promote quality of care, patient safety and cost efficiency;	**All Dental Products**

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3.	Credential and re-credential Participating Providers in accordance with CHLIC's credentialing requirements and ensure that third-party network vendors credential/re-credential Participating Providers in accordance with CHLIC's requirements;	**All Medical, Dental and Pharmacy Products**
4.	Monitor Participating Provider compliance with protocols and procedures for quality, Member satisfaction, and grievance resolution;	**All Medical, Dental and Pharmacy Products**
5.	Facilitate the identification of Participating Providers by Members; and	**All Medical, Dental and Pharmacy Products**
6.	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Medical, Dental and Pharmacy Products**
	BEHAVIORAL HEALTH	
	CHLIC has contracted with an affiliate, Cigna Behavioral Health ("CBH"), to provide or arrange for the provision of managed in-network behavioral health services, CBH is a Participating Provider, and is reimbursed primarily on a monthly fixed fee basis. This fixed fee for CBH services will be paid as claims and will appear in Employer's monthly reporting and on financial documents. Such payments will be at the relevant monthly rates then in effect. The monthly rates paid to CBH vary depending on geographic location of Members and on benefit design, and may be subject to change. The rates will be made available upon request. The fixed fee also includes lifestyle management programs, a cognitive behavioral modification program, a Complex Psychiatric Case Management program, and a Narcotics Therapy Management program. Behavioral claims from a client specific network are not included in the behavioral monthly fixed fee and will be paid from the Bank Account. In some states, payment for behavioral health services must be paid on a fee-for-service basis. In these states, fee-for-service payments for behavioral health services and the CBH administrative fee (including the lifestyle management programs, a cognitive behavioral modification program a Complex Psychiatric Case Management program and a Narcotics Therapy Management program) will be paid from the Bank Account as claims and will appear in Employer's monthly reporting.	**These services are included in the following products: OAP**

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

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Client Name: [redacted]
Administrative Services Only Agreement

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

EFFECTIVE AUGUST 1, 2014

(Applicable to all Open Access Plus Products)

Department	CPT Code	Description	OAP Rate
All Departments	99213	OFFICE VISIT,EST EXP PROB FOC	$65.80
Adult Medicine	99396	WELL EXAM, EST, 40-64 YEARS	$102.94
Pediatrics	99392	WELL EXAM, EST, 1-4 YEARS	$85.77
Gastroenterology	45378	COLONOSCOPY - Professional Fee only, at a facility	$257.75
Neurology	64615	CHEMODENERVATION OF MUSCLE MIGRAINE	$157.18
Ophthalmology	66984	REMOVE CATARACT, INSERT LEN- Professional Fee only, at a facility	$700.01
Podiatry	11721	DEBRIDEMENT NAIL SIX OR MORE	$39.95
Radiology	71020	CHEST X-RAY, PA & LAT	$30.38
Radiology	G0202 + 77052	SCREENING MAMMOGRAPHY DIGITAL	$141.02
Urology	52000	CYSTOSCOPY	$253.87
General Surgery	47562	LAPAROSCOPY;CHOLECYSTECTOMY-Professional Fee only, at a facility	$837.79
Optometry	92014	EYE EXAM & TREATMENT	$109.35
Lab	80053	COMPREHENSIVE METABOLIC PANEL	$14.87
Lab	80061	LIPID PANEL	$18.85
ASC (Ambulatory surgical center) / Endoscopy Suite	Grouper 2		$469.00
ASC (Ambulatory surgical center) / Endoscopy Suite	Grouper 8		$1,104.00

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

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

CMG pharmacy rates (30-day supply):
Brand Name: AWP – 10.56% + $2.75 dispensing fee
Generic: AWP – 35% + $2.75 dispensing fee

Exhibit C – Claim Audit Agreement (Sample)

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

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

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

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

1. Audit Specifications

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

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

2. Review of Specifications

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

3. Access to Information

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

4. Audit Report

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

5. Comment on Audit Report

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

Client Name: [redacted]
Administrative Services Only Agreement

6. Confidentiality

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

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

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

7. Restricted Use of the Audit Information

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

8. Termination

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

Client Name: [redacted].
Administrative Services Only Agreement

Cigna Health and Life Insurance Company

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date: _____

Employer: _____

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date: _____

Auditor: _____

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date: _____

Client Name: [redacted]
Administrative Services Only Agreement

Exhibit D – Privacy Addendum

("Business Associate Agreement")

I. GENERAL PROVISIONS

Section 1. Effect. As of the Effective Date, the terms and provisions of this Addendum are incorporated in and shall supersede any conflicting or inconsistent terms and provisions of (as applicable) the Administrative Services Only Agreement and/or Flexible Spending Account or Reimbursement Accounts Administrative Services Agreement to which this Addendum 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 Addendum sets out terms and provisions relating to the use and disclosure of Protected Health Information ("**PHI**") without written authorization from the Individual. To the extent there is a conflict between the Agreement and this Addendum, this Addendum shall control.

Section 2. Amendment to Comply with Law. CHLIC, on behalf of itself and its affiliates and subsidiaries that perform services under the Agreement (collectively referred to as **"CHLIC"**), Employer (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 Addendum to the extent necessary to allow either the Plan or CHLIC to comply with applicable laws and regulations including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160 to 164) ("**HIPAA Privacy and Security Rules**").

Section 3. Relationship of Parties. The parties intend that CHLIC is an independent contractor and not an agent of the Plan or the Plan Sponsor.

II. PERMITTED USES AND DISCLOSURES BY CHLIC

Section 1. Uses and Disclosures Generally. Except as otherwise provided in this Addendum, CHLIC 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. CHLIC shall not further use or disclose PHI other than as permitted or required by this Addendum, or as required by law.

Section 2. To Carry Out Plan Obligations. To the extent CHLIC is to carry out one or more of the Plan's obligations under Subpart E of 45 C.F.R. Part 164, CHLIC agrees to comply with the requirements of Subpart E that apply to the Plan in the performance of such obligations.

Section 3. Management and Administration.

(A) CHLIC may use PHI for the proper management and administration of CHLIC or to carry out the legal responsibilities of CHLIC.

(B) CHLIC may disclose PHI for the proper management and administration of CHLIC, provided that disclosures are: (a) required by law; or (b) CHLIC 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 CHLIC of any instances of which it is aware in which the confidentiality of the information has been breached.

(C) CHLIC may use or disclose PHI to provide Data Aggregation services relating to the Health Care Operations of the Plan, or to de-identify PHI. Once information is de-identified, this Addendum shall not apply.

Section 4. Required or Permitted By Law. CHLIC may use or disclose PHI as required by law or permitted by45 C.F.R. §164.512.

III. OTHER OBLIGATIONS AND ACTIVITIES OF CHLIC

Section 1. Receiving Remuneration in Exchange for PHI Prohibited. CHLIC 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. CHLIC 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 Addendum. CHLIC shall determine what constitutes the minimum necessary to accomplish the intended purpose of such disclosure.

Section 3. Security Standards. CHLIC shall use appropriate safeguards and comply with Subpart C of 45 C.F.R. 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, CHLIC shall:

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

(B) Ensure that any agent or subcontractor to whom CHLIC provides Electronic PHI agrees to implement reasonable and appropriate safeguards to protect such information; and,

(C) Promptly report to the Plan any Security Incident with respect to Electronic PHI of which it becomes aware and which has compromised the protections set forth in the HIPAA Security Rule. In the event of a Security Incident, CHLIC shall report to the Plan in writing (i) any actual, successful Security Incident within ten (10) business days of the date on which CHLIC first becomes aware of such actual, successful Security Incident and (ii) to the extent commercially reasonable, the Plan may request CHLIC to report in writing attempted but unsuccessful Security Incidents involving PHI of which CHLIC becomes aware, provided however that such reports are not required for trivial and routine incidents such as port scans, attempts to log-in with an invalid password or user name, denial of service attacks that do not result in a server being taken off-line, malware and pings or other similar types of events.

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

Section 6. Security Breach Notification. CHLIC 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 (10) business days after CHLIC'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 CHLIC 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, CHLIC is not the agent of the Plan or the Employer (as "agent" is defined under common law). CHLIC 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, CHLIC 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). In the event of a Breach affecting multiple CHLIC clients where CHLIC believes notification to affected individuals is required in accordance with applicable law, CHLIC reserves to the right to issue notifications to the affected individuals without Plan approval.

CHLIC will pay the costs of issuing notices required by law and other remediation and mitigation which, in CHLIC's discretion, are appropriate and necessary to address the Breach. CHLIC will not be required to issue notifications that are not mandated by applicable law. CHLIC 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 45 C.F.R. §164.408(c).

Section 7. Disclosures to and Agreements with Third Parties. CHLIC agrees to ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of CHLIC agree to the same restrictions, conditions and requirements that apply to CHLIC with respect to such information.

Section 8. Access to PHI. CHLIC 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 time and manner required in 45 C.F.R. §164.524.

Section 9. Availability of PHI for Amendment. CHLIC shall respond to a request by an Individual for amendment to such Individual's PHI contained in a Designated Record Set in the time and manner required in 45 C.F.R. §164.526.

Section 10. Right to Confidential Communications and to Request Restriction of Disclosures of PHI. CHLIC shall respond to a request by an Individual for confidential communications or to restrict the uses and disclosures of PHI contained in such Individual's Designated Record Set in the time and manner required by

45 C.F.R. §164.522. CHLIC shall not be obligated to agree to, or implement, any restriction, if such restriction would hinder Health Care Operations or the provision of the functions, activities or services, unless such restriction would otherwise be required by 45 C.F.R. § 164.522(a).

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

Section 12. Availability of Books and Records. CHLIC 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 CHLIC on behalf of the Plan, available to the Secretary for purposes of determining the Plan's compliance with the Privacy Rule.

Section 13. Standard Transactions. CHLIC certifies that it conducts any applicable transactions that are subject to the HIPAA standard transaction rules (45 C.F.R. Parts 160-164) as required under such rules.

IV. TERMINATION OF AGREEMENT WITH CHLIC

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 CHLIC in the event that CHLIC materially breaches any obligation of this Addendum and fails to cure the breach within such reasonable time as the Plan may provide for in such notice.

If CHLIC 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 Addendum, CHLIC 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, CHLIC may terminate the Agreement at the end of such period.

Section 2. Use and Disclosure of PHI upon Termination. The parties hereto agree that it is not feasible for CHLIC to return or destroy PHI at termination of the Agreement; therefore, the protections of this Addendum for PHI shall survive termination of the Agreement, and CHLIC 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. OBLIGATIONS OF THE PLAN AND PLAN SPONSOR

Section 1. Disclosures Generally. Except as otherwise provided for in this Addendum, the Plan will not request that CHLIC use or disclose PHI in any manner that would not be permissible under HIPAA or HITECH if done by the Plan.

Section 2. Disclosures to the Plan or Third Parties. To the extent the Plan requests that CHLIC disclose PHI either to the Plan or to a third party business associate acting for the Plan, the Plan represents and warrants that:

(A) It only will request PHI for the purposes of Treatment, Payment, or Health Care Operations, or another permitted purpose under the HIPAA Privacy Rule;

(B) The information requested is the minimum necessary to achieve the purpose of the disclosure; and

(C) If the PHI is to be disclosed to a third party, the Plan has a business associate agreement in place with the third party.

Section 3. Disclosure to Plan Sponsor. To the extent the Plan requests that CHLIC disclose PHI to the Plan Sponsor, the Plan and Plan Sponsor each represent and warrant that:

(A) The information only will be used for one of the following purposes:

i. Plan Administration functions, as defined by the HIPAA Privacy Rule, and that the Plan Sponsor has executed the required plan amendment and certification allowing the disclosure, as set out in the HIPAA Privacy Rule;

ii. Enrollment functions, provided the information to be disclosed is limited to enrollment and disenrollment information; or

iii. To amend, modify, or terminate the Plan, or to obtain premium bids to provide health insurance coverage under the Plan, provided the information to be disclosed is limited to Summary Health Information, as defined in the HIPAA Privacy Rule; and

(B) The information requested is the minimum necessary to achieve the purpose of the disclosure.

VI. DEFINITIONS FOR USE IN THIS ADDENDUM

Definitions. Certain capitalized terms used in this Addendum 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 Addendum 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 Addendum 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 Protected Health Information 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 CHLIC 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 CHLIC; any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by CHLIC 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 CHLIC.

"Covered Entity" means the 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 CHLIC for the Plan, or used, in whole or in part, by CHLIC or the Plan to make decisions about Individuals.

"Effective Date" shall mean the earliest date by which CHLIC and the Plan must enter into a business associate agreement under 45 C.F.R. Part 164.

"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 45 C.F.R. §164.514(e)(2).

"Protected Health Information" or **"PHI"** shall have the same meaning as set forth at 45 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.

Exhibit E – Conditional Claim/Subrogation Recovery Services

I. Plans Without CHLIC General Stop Loss Coverage

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

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

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

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

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

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

Name:
Title:
Address:
Telephone:

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

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

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

II. Plans with CHLIC Stop Loss Coverage

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

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

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

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

Client Name: [redacted]
Administrative Services Only Agreement

ADDENDUM A
TO
ADMINISTRATIVE SERVICES AGREEMENT
BETWEEN

[redacted] AND
CIGNA HEALTH AND LIFE INSURANCE COMPANY

AND

EMPLOYER: _____

PART A
BASIC SERVICES PROVIDED BY
[redacted]

I. BASIC SERVICES

A. PROVIDER NETWORK

(i) [redacted] shall make available a network of providers in Massachusetts and Rhode Island ("Provider Network") consisting of providers under contract, either directly with [redacted] or through Intermediaries ("Network Providers"), to deliver Plan services to Participants. Network Providers shall be compensated for Health Care Costs (as defined below) at rates, set forth in contracts governing the provision of Plan services. Employer acknowledges, that [redacted] negotiates contracts with Network Providers and Intermediaries ("Provider Agreements"), and that the Provider Network may change from time to time. Network Providers may also, at any time, limit member access to their practice based upon lawful criteria and close or open their panels. Providers may also be added to the Provider Network.

(ii) [redacted] and/or Network Providers may be unable to provide services due to circumstances beyond their control, including but not limited to a major disaster, epidemic, strike, war, terrorist act, civil insurrection, the complete or partial destruction of facilities, riot, or natural disaster. In such case, [redacted] will make a good faith effort to provide administrative services according to this Addendum, and to arrange for the provision of Plan services to Participants to the extent practical and according to [redacted] best judgment. [redacted] will incur no liability or obligation for delay or failure to meet its obligations if the failure or delay is caused by such an event.

(iii) [redacted] does not provide, health care services; rather, [redacted] arranges for health care through contracts with Intermediaries and Network Providers for Network Providers to provide health care services. Neither Intermediaries nor Network Providers are the employees, agents or representatives of [redacted] for any purposes and [redacted] is not responsible for their acts, omissions, representations or other conduct. [redacted] and its affiliates may hold minority investment interests in provider organizations and Intermediaries.

B. Health Care Costs

Health Care Costs paid to Network Providers consist of payments:

(i) made to providers, Participants, and Intermediaries (defined as organizations of providers, provider networks, and vendors);

(ii) which may be in the form of any of the following: (i) fee for service payments; (ii) fixed per person per period payments for designated services, provided, however, Employer acknowledges that prepayment of fixed per person per period charges to providers or Intermediaries for designated services does not relieve Employer's funding obligations for those designated services in the event Participants receive those services from providers not participating in the fixed per person per period reimbursement arrangement or in the event of nonperformance by providers reimbursed on a fixed per person per period basis or Intermediaries due to insolvency or otherwise; (iii) payments based upon risk sharing compensation methodologies including but not limited to DRGs, case rates, and withholds and settlements based upon achievement of aggregate performance targets; and (iv) flat fees or contingent payments based upon, for example, percentage of savings; and

(iii) which are for or related to Plan services, including but not limited to (a) claims for Plan services; (b) payments for health care cost management services provided, such as specialty case management programs; and (c) payments related to provider participation in the Provider Network, such as network access fees to Intermediaries;

C. Claim Re-pricing Services and Network Savings Fee

In connection with making available to Plan participants access to its Network Providers in Massachusetts and Rhode Island, [redacted] shall receive a fee for re-pricing claims from its Network Providers to reflect the appropriate rate of reimbursement under the terms of the [redacted] Provider Agreements. [redacted] shall receive either a per claim network savings fee for each re-priced claim or a per-employee per month network access fee for each covered employee of Employer residing in Massachusetts and Rhode Island.

Client Name: [redacted]
Administrative Services Only Agreement

PART B
BUSINESS ASSOCIATE ADDENDUM

1. **DEFINITIONS**. Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the Rules.

   1.1. The following terms used in this Addendum shall have the same meaning as those terms in the HIPAA Rules:

Breach	Individual	Secretary
Data Aggregation	Minimum Necessary	Security Incident
Designated Record Set	Notice of Privacy Practices	Subcontractor
Disclosure	Protected Health Information	Unsecured PHI
Health Care Operations	Required By Law	Use

   1.2. Subcontractor. "Subcontractor" includes both direct and indirect subcontractors (e.g., any subcontractor of a subcontractor).

   1.3. "HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164, as amended from time to time.

2. **OBLIGATIONS OF [redacted] WITH RESPECT TO PROTECTED HEALTH INFORMATION**

   2.1. [redacted] agrees not to use or disclose Protected Health Information (PHI) other than (i) as necessary to perform the Services set forth in the ASA; (ii) as permitted or required by this Addendum; or (iii) as Required by Law.

   2.2. [redacted] agrees to 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 herein.

   2.3. [redacted] agrees to mitigate, to the extent practicable, any harmful effect that is known to [redacted] of a use or disclosure of PHI by [redacted] in violation of the requirements of this Addendum.

   2.4. [redacted] agrees to report to Covered Entity any use or disclosure of the PHI not provided for by this Addendum of which it becomes aware, including breaches of unsecured PHI, and any Security Incident of which [redacted] becomes aware. In determining how and how often [redacted] shall report to Covered Entity in writing the Security Incidents required above, both Covered Entity and [redacted] agree that incidents such as unsuccessful attempts at unauthorized access and system interference occur frequently and that there is no benefit to data security from requiring the specific documentation and reporting of such unsuccessful Security Incidents. Consequently, both Covered Entity and [redacted] agree that this section 2.4 shall constitute the documentation, notice and written report of such unsuccessful attempts at unauthorized access or system interference and that no further notice or report of such attempts will be required. By way of example (and not limitation in any way), the parties consider the following to be illustrative (but not exhaustive) of Unsuccessful Security Incidents when they do not result in unauthorized access, use, or disclosure of electronic PHI or interference with an information system: pings and other broadcast attacks on a firewall, port scans, unsuccessful log-on attempts, denial of service attacks, and any combination of the above.

2.5. [redacted] shall ensure that in accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, any subcontractors or agents that create, receive, maintain, or transmit PHI on behalf of its vendors that are Business Associates of [redacted] agree in writing to the same restrictions, conditions, and requirements that apply to the vendor with respect to such information.

2.6. Within the time and in the manner prescribed by 45 C.F.R. § 164.524, [redacted] agrees to provide access as required under 45 C.F.R. § 164.524 to Individuals, following the Individual's request, to any PHI that is solely in [redacted] possession, including rights to inspect and obtain copies of PHI for so long as the PHI is maintained.

2.7. [redacted] agrees to respond to requests for amendments to PHI in a Designated Record Set requested by an Individual pursuant to 45 C.F.R. § 164.526 within the time and in the manner prescribed by 45 C.F.R. § 164.526.

2.8. [redacted] agrees to make its internal practices, books and records, including policies relating to the use and disclosure of PHI received from, or created or received by [redacted] on behalf of, Covered Entity available to the Secretary of Health and Human Services within a reasonable amount of time following the request, for the purposes of the Secretary determining Covered Entity's compliance with the HIPAA Rules. This provision shall survive termination of this Addendum.

2.9. [redacted] agrees to document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

2.10. [redacted] agrees to provide an Individual who has requested an accounting of disclosures in accordance with 45 C.F.R. § 164.528 information collected in accordance with Section 2.9 of this Addendum, within the time and in the manner prescribed by 45 C.F.R. § 164.528.

3. PERMITTED USES AND DISCLOSURES

3.1. Except as otherwise limited by this Addendum, [redacted] may use or disclose PHI on behalf of, or to provide services to, Covered Entity in order to perform Services as agreed upon by [redacted] and Covered Entity, if such use or disclosure of PHI would not violate the Privacy Rule if done by Covered Entity.

3.2. [redacted] may use the PHI for the proper management and administration of Tufts HP and to carry out the present and/or future legal and/or contractual responsibilities of Tufts HP.

3.3. [redacted] may disclose the PHI to third parties for the proper management and administration of [redacted] provided that the disclosures are Required By Law, as defined by 45 C.F.R. § 164.501, or [redacted] obtains reasonable assurances in writing from the third party that the same restrictions, conditions, and requirements that apply to the [redacted] with respect to such information also apply to such third party.

3.4. [redacted] may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

3.5. [redacted] may provide PHI to appropriate Federal and State authorities, when permitted by applicable law or when Required by Law.

3.6. [redacted] may disclose PHI to Plan Sponsor for Plan Administration Purposes. [redacted] can rely on Covered Entity's determination that such request is for only the minimum necessary data as required by the HIPAA Rules,45 CFR 64.502(b).

3.7. Upon the request of the Covered Entity, [redacted] may disclose the PHI in its possession to a Business Associate of the Covered Entity, as defined in 45 C.F.R. § 160.103. Covered Entity will ensure that if Covered Entity and/or such Business Associate requests such disclosure of PHI, the request shall be only for the minimum necessary PHI as required by the HIPAA Rules, 45 CFR 64.502(b) and that [redacted] can rely on Covered Entity's and/or the Business Associate's determination that such request is for only the minimum necessary data.

3.8. [redacted] may release Summary Health Information, as defined in 45 C.F.R. § 164.504(a), for the purposes of obtaining premium bids to provide health insurance coverage under the group health plan or for modifying, amending or terminating the group health plan.

3.9. [redacted] may de-identify any and all PHI provided that the de-identification conforms to the requirements of 45 C.F.R. § 164.514(b).

3.10. Limited Data Sets - [redacted] may use any and all PHI to create a limited data set, provided that the limited data set conforms to the requirements of 45 CFR 164.514(e)(2). [redacted] may use or disclose such limited data set for the purposes set forth in 45 CFR 164.514(e)(3). Prior to any disclosure [redacted] shall enter into a data use agreement, that conforms to the requirements of 45 CFR 164.514(e)(4), with the recipient of the limited data set.

4. **OBLIGATIONS OF COVERED ENTITY WITH RESPECT TO PROTECTED HEALTH INFORMATION**.

4.1. Covered Entity shall notify [redacted] of any limitation(s) in its notice of privacy practices in accordance with 45 C.F.R. § 164.520, prior to distributing such notice, to the extent that such limitation may affect [redacted] use or disclosure of PHI. [redacted] shall promptly notify Covered Entity if it cannot comply with the proposed limitation. If [redacted] so notifies Covered Entity, both parties agree to make good faith efforts to develop a mutually agreeable limitation.

4.2. Covered Entity shall notify [redacted] of any changes in, or revocation of, authorization by an Individual to use or disclose PHI, to the extent that such changes may affect [redacted] use or disclosure of PHI.

4.3. Covered Entity shall notify [redacted] of any restrictions to the use or disclosure of PHI that Covered Entity has been requested to agree to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect [redacted] s use or disclosure of PHI. [redacted] shall promptly notify Covered Entity if it cannot comply with the proposed restriction. If [redacted] so notifies Covered Entity, Covered Entity shall not agree to such restriction.

4.4. Covered Entity shall not request, and shall prohibit Plan Sponsor from requesting [redacted] to use or disclose PHI in any manner that would not be permissible under the HIPAA Rules if done by Covered Entity, except for uses and disclosures of PHI for data aggregation or management and administrative activities of [redacted]

4.5. Covered Entity represents and warrants that the Plan Sponsor to whom [redacted] has been requested to release PHI, pursuant to Section 3.6 of this Addendum, has amended Plan Documents and provided Covered Entity with certification pursuant to 45 C.F.R. § 164.504(f)(2). Covered Entity further represents and warrants that Covered Entity and Plan Sponsor will use PHI solely for legitimate plan administration purposes and will not use PHI for any decisions affecting an employee's employment status.

4.6. Covered Entity agrees to immediately notify [redacted] of any changes in its Business Associates to whom [redacted] has been requested to release PHI pursuant to Section 3.7 of this Addendum. Covered Entity further represents and warrants that it has entered into binding Business Associate Contracts that conform to the requirements of 45 C.F.R. § 164.504(e) with any and all Business Associates to whom [redacted] is requested to release PHI and also represents and warrants that any such request is only for the minimum necessary data as that term is defined in 45 CFR § 164.502(b) as amended from time to time.

4.7. Covered Entity represents and warrants that when required by the HIPAA Rules, it will obtain valid authorization from Individuals prior to requesting PHI from [redacted] Covered Entity further represents and warrants that it will require its Business Associates to whom [redacted] has been directed to release PHI pursuant to Section 3.7 of this Addendum, to obtain valid authorization from Individuals prior to requesting PHI from [redacted]

4.8. Covered Entity represents and warrants that if Covered Entity or another Business Associate of Covered Entity requests that PHI be provided to Covered Entity, Plan Sponsor or another Business Associate of Covered Entity, the request shall be only for the minimum necessary PHI as required by the HIPAA Rules, 45 CFR 64.502(b) and that [redacted] can rely on Covered Entity's and/or the Business Associate's determination that such request is for only the minimum necessary data.

5. TERM AND TERMINATION.

5.1. **Term.** The term of this Addendum shall begin on the Effective Date and continue for successive one year terms until terminated as provided herein. Termination of the ASA shall also terminate this Addendum. Notwithstanding the forgoing, if [redacted] provides run-out services after the termination of the ASA to provide Services, this Addendum shall remain in effect during the run-out period.

5.2. **Termination for Cause**. Upon either party's knowledge of a material breach of this Addendum by the other, the non-breaching party shall either: (1) notify the breaching party of the breach; in the event that the breach is not cured within thirty (30) calendar days after written notice describing the breach is received by the breaching party, either party may terminate this Addendum; or (2) immediately terminate this Addendum if cure is not possible.

5.3. **Effect of Termination.** Upon termination of this Addendum for any reason,

(a) [redacted] shall, if feasible, at [redacted] option, either return or destroy PHI received from Covered Entity, or created or received by [redacted] on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of [redacted] [redacted] shall retain no copies of the returned or destroyed PHI.

(b) Covered Entity acknowledges that it will not be feasible for [redacted] to return or destroy all PHI. [redacted] hereby notifies Covered Entity that it is not feasible to return or destroy any and all documentation required to be maintained by applicable law or regulation and/or Tufts HP's internal policies and procedures.

(c) [redacted] agrees to notify Covered Entity of any other conditions that make return or destruction infeasible.

[redacted] shall extend the protections of this Addendum to any PHI not returned or destroyed and agrees to limit further uses and disclosures of such PHI to those purposes that make return or destruction infeasible, for so long as [redacted] maintains such PHI. This provision shall survive termination of this Addendum.

6. **INTEGRATION WITH THE AGREEMENT TO PROVIDE SERVICES**. This Addendum shall be and hereby is incorporated into any agreement to provide Services now existing or subsequently established. The terms, agreements and obligations of the parties set forth herein shall be in addition to and shall supplement the terms, agreements and obligations of the parties. In the event of any inconsistencies, the terms and conditions of this Addendum shall prevail.

7. **INDEMNIFICATION**. Each party shall indemnify and hold harmless the other, its agents, officers and employees (in their capacity of employees of Sponsor and/or [redacted] and not as Members of the health benefits plan) from all damages, losses, obligations, liabilities, claims, costs and expenses (including reasonable attorney fees, penalties, and fines) incurred by the indemnified party, its agents, officers and employees incident to any threatened or actual claim, demand, suit, penalty, investigation or action that relates to or arises out of the indemnifying party's negligence, fraud or criminal conduct in the performance of this Addendum.

8. **COMPLIANCE WITH LAW**. Both parties agree to comply with all applicable state and federal privacy and data protection laws, including the HIPAA Rules.

9. **RELATIONSHIP OF PARTIES**. Each party is and shall be construed an independent contractor, and no party shall be deemed to be the agent or partner or joint venturer with the other, nor have any relationship as a result of this Addendum other than as independent contractors.

10. **SEVERABILITY**. If any provision of this Addendum is unenforceable, invalid or violates applicable law, such provision shall be deemed stricken and shall not affect the enforceability of any other provisions of this Addendum.

11. **AMENDMENT**. This Addendum may only be amended or modified by written agreement of both parties. The parties agree to take such action as is necessary to amend this Addendum from time to time as is necessary to comply with the requirements of the HIPAA Rules and applicable privacy and data security laws.

12. **INTERPRETATION**. Any ambiguity in this Addendum shall be resolved to permit compliance with the HIPAA Rules.

APPENDIX A

Cigna Home Delivery Pharmacy Specialty Drug List

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

Currently Marketed Specialty Drugs on this Specialty Drug List. The discounts in this Specialty Drug List are the discounts that will be adjudicated in Cigna's claim processing system for the drug indicated when dispensed by Cigna Home Delivery Pharmacy, subject to all of the following.

- Any or all of the discounts in this Specialty Drug List may be adjusted by Cigna in the event of a major change in market conditions affecting the pharmaceutical or pharmacy benefit management market, a drug shortage in the market, an issue involving the safety of the drug supply, or similar market situation.

- The discounts in this Specialty Drug List are based on the terms and design of the Pharmacy Benefit that Employer has adopted and disclosed to Cigna. Accordingly, if Employer fails to disclose to Cigna, for example, that it uses or intends to use a consumer-driven health plan, a major cost-sharing program, or a utilization management program promoting generic or OTC drugs over brand drugs, Cigna may adjust the discounts.

- The discounts in this Specialty Drug List shall not apply to compound drug claims, claims that process at U&C, and direct member reimbursement (DMR) claims.

- Any or all of the discounts in this Specialty Drug List may be adjusted by Cigna if (a) there are any significant changes in the composition of Cigna's pharmacy network or in Cigna's pharmacy network contract compensation rates, or the structure of the pharmacy stores/chains/vendors that are contracted with Cigna, including but not limited to disruption in the retail pharmacy delivery model, or bankruptcy of a chain pharmacy; or (b) there is a change in government laws or regulations which has a significant impact on pharmacy claim costs; or (c) any material manufacturer-rebate contracts with or for the benefit of Cigna are terminated or modified in whole or in part; or (d) there is any legal action or Law that materially affects or could materially affect the manner in which Cigna's rebate program is administered or an existing Law is interpreted so as to materially affect or potentially have a material effect on Cigna's administration of the Pharmacy Benefit; or (e) there is a material change in the Plan or the Plan's Pharmacy Benefit that is initiated by Employer which impacts Cigna's costs.

- For Specialty Drugs marked with an asterisk (*), Cigna remits Rebates to Employer solely through the drug discount level for Specialty Drug Claims processed through Cigna Home Delivery Pharmacy. The purchase discount Rebate provided to the Employer for such Specialty Drugs is calculated by reducing the Specialty Drug's purchase price at the point of reimbursement by any applicable Rebates collected by Cigna and payable to Employer. These discounts may be adjusted by Cigna in the event of changes in preferred drug strategies, opportunities to improve net cost, product additions to or removals from the marketplace, or other factors that may impact the Specialty Drug purchase discounts, provided that Cigna adjusts any or all such discounts as it reasonably deems necessary to preserve the economic value or benefit of this Agreement as it existed immediately prior to such replacement. No other manufacturer rebates or remuneration arising from such Specialty Drugs shall be payable by Cigna to Employer.

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

Client Name: [redacted].
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EXCHANGE Level Specialty Drug List		
Cigna HOME DELIVERY SPECIALTY DRUG DISCOUNTS		
BRANDS		
CONDITION	**BRAND NAME**	**AWP DISCOUNT**
ALS	RILUTEK	20.00%
AMD	EYLEA	11.45%
ANGIOEDEMA	FIRAZYR	20.00%
ANTI-COAGULANT	ARGATROBAN	15.00%
ANTI-INFECTIVE	BETHKIS	20.00%
ANTI-INFECTIVE	CYTOGAM	11.45%
ANTI-INFECTIVE	CYTOVENE	11.45%
ANTI-INFECTIVE	FUZEON	20.00%
ANTI-INFECTIVE	KITABIS PAK	20.00%
ANTI-INFECTIVE	TOBI	20.00%
ANTI-INFECTIVE	TOBI PODHALER	20.00%
ANTI-INFECTIVE	VISTIDE	11.45%
ANTI-PSYCHOTIC	NUPLAZID	20.00%
ANTITHROMBIN III DEFICIENCY	ATRYN	11.45%
APLASTIC ANEMIA	PROMACTA	20.00%
ASTHMA	CINQAIR	20.00%

Client Name: [redacted]
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ASTHMA	XOLAIR	20.00%
BILIARY CIRRHOSIS	OCALIVA	20.00%
CANCER - ANCILLARY/ADJUVANT	AKYNZEO	20.00%
CANCER - ANCILLARY/ADJUVANT	ALOXI	11.45%
CANCER - ANCILLARY/ADJUVANT	ANZEMET	20.00%
CANCER - ANCILLARY/ADJUVANT	ARANESP	20.00%
CANCER - ANCILLARY/ADJUVANT	COMETRIQ	20.00%
CANCER - ANCILLARY/ADJUVANT	ELIGARD	11.45%
CANCER - ANCILLARY/ADJUVANT	ELITEK	11.45%
CANCER - ANCILLARY/ADJUVANT	EMEND	20.00%
CANCER - ANCILLARY/ADJUVANT	EPOGEN	20.00%
CANCER - ANCILLARY/ADJUVANT	ETHYOL	11.45%
CANCER - ANCILLARY/ADJUVANT	FIRMAGON	20.00%
CANCER - ANCILLARY/ADJUVANT	FUSILEV	11.45%
CANCER - ANCILLARY/ADJUVANT	GRANIX	11.45%
CANCER - ANCILLARY/ADJUVANT	GRANIX	20.00%
CANCER - ANCILLARY/ADJUVANT	LEUCOVORIN	20.00%
CANCER - ANCILLARY/ADJUVANT	LEUKINE	11.45%
CANCER - ANCILLARY/ADJUVANT	LUPANETA	20.00%
CANCER - ANCILLARY/ADJUVANT	LUPRON DEPOT	15.00%

CANCER - ANCILLARY/ADJUVANT	LUPRON DEPOT	20.00%
CANCER - ANCILLARY/ADJUVANT	LUPRON DEPOT-PED	20.00%
CANCER - ANCILLARY/ADJUVANT	MESNEX	11.45%
CANCER - ANCILLARY/ADJUVANT	MESNEX	20.00%
CANCER - ANCILLARY/ADJUVANT	NEULASTA	13.00%
CANCER - ANCILLARY/ADJUVANT	NEULASTA	20.00%
CANCER - ANCILLARY/ADJUVANT	NEUMEGA	20.00%
CANCER - ANCILLARY/ADJUVANT	NEUPOGEN	13.00%
CANCER - ANCILLARY/ADJUVANT	NEUPOGEN	20.00%
CANCER - ANCILLARY/ADJUVANT	PROCRIT	20.00%
CANCER - ANCILLARY/ADJUVANT	VARUBI	20.00%
CANCER - ANCILLARY/ADJUVANT	VISTOGARD	20.00%
CANCER - ANCILLARY/ADJUVANT	VORAXAZE	11.45%
CANCER - ANCILLARY/ADJUVANT	ZARXIO	20.00%
CANCER - ANCILLARY/ADJUVANT	ZOLADEX	20.00%
CANCER - CHEMOTHERAPY	ABRAXANE	11.45%
CANCER - CHEMOTHERAPY	ADCETRIS	15.00%
CANCER - CHEMOTHERAPY	ADRIAMYCIN	11.45%
CANCER - CHEMOTHERAPY	ADRIAMYCIN RDF	11.45%
CANCER - CHEMOTHERAPY	AFINITOR	20.00%

CANCER - CHEMOTHERAPY	AFINITOR DISPERZ	20.00%
CANCER - CHEMOTHERAPY	AGRYLIN	20.00%
CANCER - CHEMOTHERAPY	ALECENSA	20.00%
CANCER - CHEMOTHERAPY	ALIMTA	11.45%
CANCER - CHEMOTHERAPY	ALKERAN	11.45%
CANCER - CHEMOTHERAPY	ALKERAN	13.54%
CANCER - CHEMOTHERAPY	ALKERAN	20.00%
CANCER - CHEMOTHERAPY	ARRANON	11.45%
CANCER - CHEMOTHERAPY	ARZERRA	11.45%
CANCER - CHEMOTHERAPY	AVASTIN	11.45%
CANCER - CHEMOTHERAPY	BELEODAQ	11.45%
CANCER - CHEMOTHERAPY	BENDEKA	15.00%
CANCER - CHEMOTHERAPY	BEXXAR	11.45%
CANCER - CHEMOTHERAPY	BICNU	11.45%
CANCER - CHEMOTHERAPY	BICNU	20.00%
CANCER - CHEMOTHERAPY	BLINCYTO	20.00%
CANCER - CHEMOTHERAPY	BOSULIF	20.00%
CANCER - CHEMOTHERAPY	BUSULFEX	11.45%
CANCER - CHEMOTHERAPY	CABOMETYX	20.00%
CANCER - CHEMOTHERAPY	CAMPATH	11.45%

Client Name: [redacted].
Administrative Services Only Agreement

CANCER - CHEMOTHERAPY	CAMPTOSAR	11.45%
CANCER - CHEMOTHERAPY	CAPRELSA	20.00%
CANCER - CHEMOTHERAPY	CASODEX	20.00%
CANCER - CHEMOTHERAPY	CERUBIDINE	11.45%
CANCER - CHEMOTHERAPY	CLOLAR	11.45%
CANCER - CHEMOTHERAPY	COSMEGEN	11.45%
CANCER - CHEMOTHERAPY	COTELLIC	20.00%
CANCER - CHEMOTHERAPY	CYRAMZA	11.45%
CANCER - CHEMOTHERAPY	DACOGEN	11.45%
CANCER - CHEMOTHERAPY	DARZALEX	20.00%
CANCER - CHEMOTHERAPY	DAUNOXOME	11.45%
CANCER - CHEMOTHERAPY	DEPOCYT	11.45%
CANCER - CHEMOTHERAPY	DOCEFREZ	11.45%
CANCER - CHEMOTHERAPY	DOXIL	11.45%
CANCER - CHEMOTHERAPY	DOXORUBICIN	16.66%
CANCER - CHEMOTHERAPY	DTIC-DOME IV	38.00%
CANCER - CHEMOTHERAPY	ELLENCE	11.45%
CANCER - CHEMOTHERAPY	ELOXATIN	11.45%
CANCER - CHEMOTHERAPY	ELSPAR	11.45%
CANCER - CHEMOTHERAPY	EMCYT	20.00%

Client Name: [redacted]
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CANCER - CHEMOTHERAPY	EMPLICITI	15.00%
CANCER - CHEMOTHERAPY	ERBITUX	11.45%
CANCER - CHEMOTHERAPY	ERIVEDGE	20.00%
CANCER - CHEMOTHERAPY	ERWINAZE	11.45%
CANCER - CHEMOTHERAPY	ETOPOPHOS	11.45%
CANCER - CHEMOTHERAPY	EVOMELA	11.45%
CANCER - CHEMOTHERAPY	FARYDAK	20.00%
CANCER - CHEMOTHERAPY	FASLODEX	11.45%
CANCER - CHEMOTHERAPY	FLUDARA	11.45%
CANCER - CHEMOTHERAPY	FOLOTYN	11.45%
CANCER - CHEMOTHERAPY	FUDR	11.45%
CANCER - CHEMOTHERAPY	GAZYVA	20.00%
CANCER - CHEMOTHERAPY	GEMZAR	11.45%
CANCER - CHEMOTHERAPY	GILOTRIF	20.00%
CANCER - CHEMOTHERAPY	GLEEVEC	20.00%
CANCER - CHEMOTHERAPY	GLIADEL	12.92%
CANCER - CHEMOTHERAPY	GLIADEL WAFER	12.91%
CANCER - CHEMOTHERAPY	HALAVEN	11.45%
CANCER - CHEMOTHERAPY	HERCEPTIN	11.45%
CANCER - CHEMOTHERAPY	HEXALEN	20.00%

Client Name: [redacted].
Administrative Services Only Agreement

CANCER - CHEMOTHERAPY	HYCAMTIN	13.54%
CANCER - CHEMOTHERAPY	HYCAMTIN	20.00%
CANCER - CHEMOTHERAPY	IBRANCE	20.00%
CANCER - CHEMOTHERAPY	ICLUSIG	20.00%
CANCER - CHEMOTHERAPY	IDAMYCIN PFS	11.45%
CANCER - CHEMOTHERAPY	IFEX	11.45%
CANCER - CHEMOTHERAPY	IMBRUVICA	20.00%
CANCER - CHEMOTHERAPY	IMLYGIC	20.00%
CANCER - CHEMOTHERAPY	INLYTA	20.00%
CANCER - CHEMOTHERAPY	ISTODAX	11.45%
CANCER - CHEMOTHERAPY	IXEMPRA	11.45%
CANCER - CHEMOTHERAPY	JEVTANA	11.45%
CANCER - CHEMOTHERAPY	KEYTRUDA	11.45%
CANCER - CHEMOTHERAPY	KYPROLIS	11.45%
CANCER - CHEMOTHERAPY	LENVIMA	13.54%
CANCER - CHEMOTHERAPY	LENVIMA	20.00%
CANCER - CHEMOTHERAPY	LONSURF	20.00%
CANCER - CHEMOTHERAPY	LYNPARZA	20.00%
CANCER - CHEMOTHERAPY	MARQIBO KIT	11.45%
CANCER - CHEMOTHERAPY	MATULANE	20.00%

CANCER - CHEMOTHERAPY	MEKINIST	20.00%
CANCER - CHEMOTHERAPY	MUSTARGEN	11.45%
CANCER - CHEMOTHERAPY	NAVELBINE	11.45%
CANCER - CHEMOTHERAPY	NEXAVAR	20.00%
CANCER - CHEMOTHERAPY	NEXAVIR	11.45%
CANCER - CHEMOTHERAPY	NINLARO	20.00%
CANCER - CHEMOTHERAPY	NIPENT	11.45%
CANCER - CHEMOTHERAPY	ODOMZO	20.00%
CANCER - CHEMOTHERAPY	ONCASPAR	11.45%
CANCER - CHEMOTHERAPY	ONIVYDE	20.00%
CANCER - CHEMOTHERAPY	ONTAK	11.45%
CANCER - CHEMOTHERAPY	OPDIVO	11.45%
CANCER - CHEMOTHERAPY	PANRETIN	11.45%
CANCER - CHEMOTHERAPY	PERJETA	11.45%
CANCER - CHEMOTHERAPY	POMALYST	20.00%
CANCER - CHEMOTHERAPY	PORTRAZZA	15.00%
CANCER - CHEMOTHERAPY	PROLEUKIN	20.00%
CANCER - CHEMOTHERAPY	PROVENGE	11.45%
CANCER - CHEMOTHERAPY	REVLIMID	20.00%
CANCER - CHEMOTHERAPY	RITUXAN	11.45%

CANCER - CHEMOTHERAPY	SPRYCEL	20.00%
CANCER - CHEMOTHERAPY	STIVARGA	20.00%
CANCER - CHEMOTHERAPY	SUPPRELIN	20.00%
CANCER - CHEMOTHERAPY	SUPPRELIN LA	11.45%
CANCER - CHEMOTHERAPY	SUTENT	20.00%
CANCER - CHEMOTHERAPY	SYLATRON	20.00%
CANCER - CHEMOTHERAPY	SYLATRON 4-PACK	20.00%
CANCER - CHEMOTHERAPY	SYNRIBO	11.45%
CANCER - CHEMOTHERAPY	TAFINLAR	20.00%
CANCER - CHEMOTHERAPY	TAGRISSO	20.00%
CANCER - CHEMOTHERAPY	TARCEVA	20.00%
CANCER - CHEMOTHERAPY	TARGRETIN	13.54%
CANCER - CHEMOTHERAPY	TARGRETIN	20.00%
CANCER - CHEMOTHERAPY	TASIGNA	20.00%
CANCER - CHEMOTHERAPY	TAXOTERE	11.45%
CANCER - CHEMOTHERAPY	TECENTRIQ	11.45%
CANCER - CHEMOTHERAPY	TEMODAR	13.54%
CANCER - CHEMOTHERAPY	TEMODAR	20.00%
CANCER - CHEMOTHERAPY	THALOMID	20.00%
CANCER - CHEMOTHERAPY	TORISEL	11.45%

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CANCER - CHEMOTHERAPY	TREANDA	11.45%
CANCER - CHEMOTHERAPY	TRELSTAR	11.45%
CANCER - CHEMOTHERAPY	TRELSTAR DEPOT	11.45%
CANCER - CHEMOTHERAPY	TRELSTAR LA	11.45%
CANCER - CHEMOTHERAPY	TRISENOX	11.45%
CANCER - CHEMOTHERAPY	TYKERB	20.00%
CANCER - CHEMOTHERAPY	UNITUXIN	15.00%
CANCER - CHEMOTHERAPY	VALCHLOR	11.45%
CANCER - CHEMOTHERAPY	VALSTAR	11.45%
CANCER - CHEMOTHERAPY	VANTAS	20.00%
CANCER - CHEMOTHERAPY	VECTIBIX	11.45%
CANCER - CHEMOTHERAPY	VELCADE	11.45%
CANCER - CHEMOTHERAPY	VENCLEXTA	20.00%
CANCER - CHEMOTHERAPY	VIDAZA	11.45%
CANCER - CHEMOTHERAPY	VOTRIENT	20.00%
CANCER - CHEMOTHERAPY	VUMON	11.45%
CANCER - CHEMOTHERAPY	XALKORI	20.00%
CANCER - CHEMOTHERAPY	XELODA	13.54%
CANCER - CHEMOTHERAPY	XELODA	20.00%
CANCER - CHEMOTHERAPY	XTANDI	20.00%

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CANCER - CHEMOTHERAPY	YERVOY	11.45%
CANCER - CHEMOTHERAPY	YONDELIS	20.00%
CANCER - CHEMOTHERAPY	ZALTRAP	11.45%
CANCER - CHEMOTHERAPY	ZANOSAR	11.45%
CANCER - CHEMOTHERAPY	ZELBORAF	20.00%
CANCER - CHEMOTHERAPY	ZEVALIN	11.45%
CANCER - CHEMOTHERAPY	ZOLINZA	20.00%
CANCER - CHEMOTHERAPY	ZYDELIG	20.00%
CANCER - CHEMOTHERAPY	ZYKADIA	20.00%
CANCER - CHEMOTHERAPY	ZYTIGA	20.00%
CERVICAL DYSTONIA	XEOMIN	20.00%
CHRONIC KIDNEY DISEASE	OMONTYS	20.00%
CYSTIC FIBROSIS	KALYDECO	20.00%
CYSTIC FIBROSIS	ORKAMBI	20.00%
CYSTINOSIS	CYSTAGON	20.00%
ENZYME DISORDER	ADAGEN	11.45%
ENZYME DISORDER	ALDURAZYME	12.00%
ENZYME DISORDER	ARALAST	11.45%
ENZYME DISORDER	ARALAST NP	13.54%
ENZYME DISORDER	CERDELGA	20.00%

Client Name: [redacted].
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ENZYME DISORDER	CEREDASE	12.00%
ENZYME DISORDER	CEREZYME	12.00%
ENZYME DISORDER	ELAPRASE	11.45%
ENZYME DISORDER	ELELYSO	11.45%
ENZYME DISORDER	FABRAZYME	12.00%
ENZYME DISORDER	GLASSIA	11.45%
ENZYME DISORDER	LUMIZYME	12.00%
ENZYME DISORDER	LUMIZYME	20.00%
ENZYME DISORDER	MYOZYME	12.00%
ENZYME DISORDER	NAGLAZYME	12.00%
ENZYME DISORDER	PROCYSBI DR	20.00%
ENZYME DISORDER	PROLASTIN	11.45%
ENZYME DISORDER	PROLASTIN C	11.45%
ENZYME DISORDER	STRENSIQ	20.00%
ENZYME DISORDER	SUCRAID	20.00%
ENZYME DISORDER	VIMIZIM	15.00%
ENZYME DISORDER	VPRIV	12.00%
ENZYME DISORDER	ZAVESCA	20.00%
ENZYME DISORDER	ZEMAIRA	11.45%
FACTOR X DEFICIENCY	COAGADEX	26.50%

GROWTH HORMONE DEFICIENCY	EGRIFTA	20.00%
GROWTH HORMONE DEFICIENCY	GATTEX	20.00%
GROWTH HORMONE DEFICIENCY	GENOTROPIN	20.00%
GROWTH HORMONE DEFICIENCY	HUMATROPE	20.00%
GROWTH HORMONE DEFICIENCY	INCRELEX	20.00%
GROWTH HORMONE DEFICIENCY	NORDITROPIN	20.00%
GROWTH HORMONE DEFICIENCY	NORDITROPIN FLEXPRO	20.00%
GROWTH HORMONE DEFICIENCY	NORDITROPIN NORDIFLEX	20.00%
GROWTH HORMONE DEFICIENCY	NUTROPIN	20.00%
GROWTH HORMONE DEFICIENCY	NUTROPIN AQ	20.00%
GROWTH HORMONE DEFICIENCY	NUTROPIN AQ NUSPIN	20.00%
GROWTH HORMONE DEFICIENCY	OMNITROPE	20.00%
GROWTH HORMONE DEFICIENCY	SAIZEN	20.00%
GROWTH HORMONE DEFICIENCY	SEROSTIM	20.00%
GROWTH HORMONE DEFICIENCY	TEV-TROPIN	20.00%
GROWTH HORMONE DEFICIENCY	ZORBTIVE	20.00%
HAE	BERINERT	20.00%
HAE	CINRYZE	11.45%
HEMOPHILIA	ADVATE	34.00%
HEMOPHILIA	ADVATE H	34.00%

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HEMOPHILIA	ADVATE L	34.00%
HEMOPHILIA	ADVATE M	34.00%
HEMOPHILIA	ADVATE SH	34.00%
HEMOPHILIA	ADVATE UH	34.00%
HEMOPHILIA	ADYNOVATE	26.50%
HEMOPHILIA	AFSTYLA	26.50%
HEMOPHILIA	ALPHANATE	32.00%
HEMOPHILIA	ALPHANINE SD	36.00%
HEMOPHILIA	ALPROLIX	11.00%
HEMOPHILIA	AMICAR	20.00%
HEMOPHILIA	APROLIX	26.50%
HEMOPHILIA	BEBULIN	11.45%
HEMOPHILIA	BEBULIN VH IMMUNO	41.66%
HEMOPHILIA	BENEFIX	13.50%
HEMOPHILIA	CORIFACT	11.45%
HEMOPHILIA	CYKLOKAPRON	11.45%
HEMOPHILIA	ELOCTATE	25.00%
HEMOPHILIA	FEIBA	28.00%
HEMOPHILIA	FEIBA NF	28.00%
HEMOPHILIA	FEIBA VH IMMUNO	28.00%

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HEMOPHILIA	HELIXATE	31.25%
HEMOPHILIA	HEMOFIL M	40.00%
HEMOPHILIA	HUMATE-P	30.00%
HEMOPHILIA	IDELVION	15.00%
HEMOPHILIA	IXINITY	24.00%
HEMOPHILIA	KOATE	30.20%
HEMOPHILIA	KOATE-DVI	30.20%
HEMOPHILIA	KOGENATE	36.45%
HEMOPHILIA	KOGENATE FS	36.45%
HEMOPHILIA	KOVALTRY	34.00%
HEMOPHILIA	LYSTEDA	11.45%
HEMOPHILIA	MONOCLATE	30.00%
HEMOPHILIA	MONOCLATE-P	30.00%
HEMOPHILIA	MONONINE	24.00%
HEMOPHILIA	NOVOEIGHT	26.50%
HEMOPHILIA	NOVOSEVEN	26.50%
HEMOPHILIA	NOVOSEVEN	35.41%
HEMOPHILIA	NOVOSEVEN RT	26.50%
HEMOPHILIA	NUWIQ	26.50%
HEMOPHILIA	OBIZUR	31.25%

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HEMOPHILIA	PROFILNINE SD	22.50%
HEMOPHILIA	RECOMBINATE	37.50%
HEMOPHILIA	RIXUBIS	30.00%
HEMOPHILIA	STIMATE	11.45%
HEMOPHILIA	THROMBATE III	11.45%
HEMOPHILIA	TRETTEN	11.45%
HEMOPHILIA	VONVENDI	26.50%
HEMOPHILIA	WILATE	25.00%
HEMOPHILIA	XYNTHA	30.00%
HEMOPHILIA	XYNTHA SOLOFUSE	30.00%
HEPATITIS B	BARACLUDE	20.00%
HEPATITIS B	HEPAGAM B	11.45%
HEPATITIS B	HEPSERA	20.00%
HEPATITIS B	HYPERHEP B S-D	11.45%
HEPATITIS B	NABI-HB	11.45%
HEPATITIS B	TALTZ	20.00%
HEPATITIS B	TYZEKA	20.00%
HEPATITIS C	ALFERON N	11.45%
HEPATITIS C	COPEGUS	20.00%
HEPATITIS C	DAKLINZA	13.54%

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HEPATITIS C	DAKLINZA	20.00%
HEPATITIS C	EPCLUSA	20.00%
HEPATITIS C	HARVONI	48.90%
HEPATITIS C	INCIVEK	20.00%
HEPATITIS C	INFERGEN	20.00%
HEPATITIS C	INTRON	20.00%
HEPATITIS C	INTRON A	20.00%
HEPATITIS C	OLYSIO	20.00%
HEPATITIS C	PEGASYS	20.00%
HEPATITIS C	PEGASYS PROCLICK	20.00%
HEPATITIS C	PEGINTRON	20.00%
HEPATITIS C	PEGINTRON REDIPEN	20.00%
HEPATITIS C	REBETOL	20.00%
HEPATITIS C	RIBAPAK	20.00%
HEPATITIS C	RIBAPAK 400-400 MG DOSEPACK	16.00%
HEPATITIS C	RIBAPAK 600-400 MG DOSEPACK	19.28%
HEPATITIS C	RIBAPAK 600-600 MG DOSEPACK	21.05%
HEPATITIS C	RIBASPHERE	75.00%
HEPATITIS C	RIBATAB	20.00%
HEPATITIS C	SOVALDI	32.30%

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HEPATITIS C	TECHNIVIE	20.00%
HEPATITIS C	VICTRELIS	20.00%
HEPATITIS C	VIEKIRA	20.00%
HEPATITIS C	ZEPATIER	20.00%
HEREDITARY OROTIC ACIDURIA	XURIDEN GRANULE	20.00%
HIV	APTIVUS	20.00%
HIV	ATRIPLA	20.00%
HIV	COMBIVIR	20.00%
HIV	COMPLERA	20.00%
HIV	CRIXIVAN	20.00%
HIV	DESCOVY	20.00%
HIV	EDURANT	20.00%
HIV	EMTRIVA	20.00%
HIV	EPIVIR	20.00%
HIV	EPIVIR HBV	20.00%
HIV	EPZICOM	20.00%
HIV	EVOTAZ	20.00%
HIV	FUZEON	20.00%
HIV	GENVOYA	20.00%
HIV	INTELENCE	20.00%

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HIV	INVIRASE	20.00%
HIV	ISENTRESS	20.00%
HIV	KALETRA	20.00%
HIV	LEXIVA	20.00%
HIV	NORVIR	20.00%
HIV	ODEFSEY	20.00%
HIV	PREZCOBIX	20.00%
HIV	PREZISTA	20.00%
HIV	RESCRIPTOR	20.00%
HIV	RETROVIR	13.54%
HIV	RETROVIR	20.00%
HIV	REYATAZ	20.00%
HIV	SELZENTRY	20.00%
HIV	STRIBILD	20.00%
HIV	SUSTIVA	20.00%
HIV	TIVICAY	20.00%
HIV	TRIUMEQ	20.00%
HIV	TRIZIVIR	20.00%
HIV	TRUVADA	20.00%
HIV	TYBOST	20.00%

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HIV	VIDEX	20.00%
HIV	VIDEX EC	20.00%
HIV	VIRACEPT	20.00%
HIV	VIRAMUNE	20.00%
HIV	VIRAMUNE XR	20.00%
HIV	VIREAD	20.00%
HIV	VITEKTA	20.00%
HIV	ZERIT	20.00%
HIV	ZIAGEN	20.00%
HIV - SUPPORTIVE	EGRIFTA	20.00%
HIV/HEPATITIS B	VIREAD	20.00%
HOMOCYSTINURIA	CYSTADANE	20.00%
HYPERCALCEMIA	ZOMETA	15.00%
HYPERLIPIDEMIA	PRALUENT	20.00%
HYPERLIPIDEMIA	REPATHA	20.00%
HYPONATREMIA	SAMSCA	20.00%
INFERTILITY	BRAVELLE	11.45%
INFERTILITY	CETROTIDE	13.00%
INFERTILITY	FERTINEX	17.00%
INFERTILITY	FOLLISTIM AQ	13.00%

INFERTILITY	GONAL-F	13.00%
INFERTILITY	GONAL-F RFF	13.00%
INFERTILITY	LUTREPULSE	11.45%
INFERTILITY	LUVERIS	11.45%
INFERTILITY	MENOPUR	13.00%
INFERTILITY	NOVAREL	13.00%
INFERTILITY	OVIDREL	20.00%
INFERTILITY	PREGNYL	13.00%
INFERTILITY	PROFASI	17.00%
INFERTILITY	REPRONEX	13.00%
IVIG	BIVIGAM	27.08%
IVIG	CARIMUNE NF NANOFILTERED	30.00%
IVIG	FLEBOGAMMA DIF	20.00%
IVIG	FLEBOGAMMA DIF	27.08%
IVIG	GAMASTAN S-D	18.00%
IVIG	GAMMAGARD	37.00%
IVIG	GAMMAGARD LIQUID	33.00%
IVIG	GAMMAGARD S-D	37.00%
IVIG	GAMMAKED	32.50%
IVIG	GAMMAPLEX	27.08%

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IVIG	GAMUNEX	27.08%
IVIG	GAMUNEX	28.00%
IVIG	GAMUNEX-C	28.00%
IVIG	HIZENTRA	28.00%
IVIG	HYQVIA	27.00%
IVIG	OCTAGAM	40.00%
IVIG	PRIVIGEN	35.00%
IVIG	VIVAGLOBIN	11.45%
LYSOSOMAL ACID LIPASE DEFICIENCY	KANUMA	17.00%
MULTIPLE SCLEROSIS	AMPYRA	20.00%
MULTIPLE SCLEROSIS	AUBAGIO	20.00%
MULTIPLE SCLEROSIS	AVONEX	20.00%
MULTIPLE SCLEROSIS	BETASERON	20.00%
MULTIPLE SCLEROSIS	COPAXONE	20.00%
MULTIPLE SCLEROSIS	COPAXONE	25.00%
MULTIPLE SCLEROSIS	EXTAVIA	20.00%
MULTIPLE SCLEROSIS	GILENYA	20.00%
MULTIPLE SCLEROSIS	LEMTRADA	11.45%
MULTIPLE SCLEROSIS	PLEGRIDY	20.00%
MULTIPLE SCLEROSIS	REBIF	20.00%

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MULTIPLE SCLEROSIS	REBIF REBIDOSE	20.00%
MULTIPLE SCLEROSIS	TECFIDERA	12.00%
MULTIPLE SCLEROSIS	TECFIDERA	20.00%
MULTIPLE SCLEROSIS	TYSABRI	15.00%
MULTIPLE SCLEROSIS	ZINBRYTA	20.00%
MYELOFIBROSIS	JAKAFI	20.00%
OSTEOARTHRITIS	HYMOVIS	11.45%
OTHER	ACTHAR H.P.	8.55%
OTHER	ACTHREL	11.45%
OTHER	ACTIMMUNE	20.00%
OTHER	AMVISC	15.00%
OTHER	AMVISC PLUS	15.00%
OTHER	ARCALYST	20.00%
OTHER	ARIXTRA	11.45%
OTHER	ARIXTRA	20.00%
OTHER	BONIVA	11.45%
OTHER	BOTOX	11.45%
OTHER	BOTOX COSMETIC	11.45%
OTHER	CHOLBAM	20.00%
OTHER	DDAVP	11.45%

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OTHER	DYSPORT	11.45%
OTHER	ESBRIET	20.00%
OTHER	EXJADE	20.00%
OTHER	FORTEO	11.45%
OTHER	FRAGMIN	11.45%
OTHER	HP ACTHAR	20.00%
OTHER	HYALGAN	11.45%
OTHER	HYALGAN	16.00%
OTHER	HYLENEX	11.45%
OTHER	HYLENEX	20.00%
OTHER	HYPERRAB S-D	11.45%
OTHER	ILARIS	20.00%
OTHER	ILUVIEN	20.00%
OTHER	IMOGAM RABIES-HT	11.45%
OTHER	IPRIVASK	11.45%
OTHER	JADENU	20.00%
OTHER	JETREA	11.45%
OTHER	JUXTAPID	20.00%
OTHER	KALBITOR	11.45%
OTHER	KCENTRA	11.45%

OTHER	KRYSTEXXA	11.45%
OTHER	KUVAN	11.45%
OTHER	KYNAMRO	20.00%
OTHER	LILETTA	20.00%
OTHER	LOVENOX	11.45%
OTHER	LUCENTIS	11.45%
OTHER	MACUGEN	11.45%
OTHER	MIRCERA	20.00%
OTHER	MIRENA	20.00%
OTHER	MONOVISC	11.45%
OTHER	MOZOBIL	11.45%
OTHER	MYALEPT	20.00%
OTHER	MYOBLOC	11.45%
OTHER	NATPARA	20.00%
OTHER	NATRECOR	11.45%
OTHER	NORTHERA	13.54%
OTHER	NORTHERA	20.00%
OTHER	NPLATE	11.45%
OTHER	OFEV	20.00%
OTHER	ORFADIN	20.00%

OTHER	ORTHOVISC	11.45%
OTHER	PHOTOFRIN	11.45%
OTHER	PRAXBIND	11.45%
OTHER	PRIALT	11.45%
OTHER	PROLIA	11.45%
OTHER	PROMACTA	20.00%
OTHER	PULMOZYME	20.00%
OTHER	RECLAST	11.45%
OTHER	REFLUDAN	11.45%
OTHER	RIASTAP	11.45%
OTHER	RIASTAP	23.00%
OTHER	RUCONEST	11.45%
OTHER	SABRIL	13.54%
OTHER	SABRIL	20.00%
OTHER	SANDOSTATIN	20.00%
OTHER	SANDOSTATIN LAR	12.50%
OTHER	SANDOSTATIN LAR	20.00%
OTHER	SENSIPAR	20.00%
OTHER	SIGNIFOR	20.00%
OTHER	SKYLA	20.00%

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OTHER	SOLIRIS	12.83%
OTHER	SOMATULINE DEPOT	20.00%
OTHER	SOMAVERT	20.00%
OTHER	SYNAREL	11.45%
OTHER	SYNVISC	14.80%
OTHER	SYNVISC-ONE	14.80%
OTHER	THYROGEN	11.45%
OTHER	VIRAZOLE	20.00%
OTHER	VISUDYNE	11.45%
OTHER	VIVITROL	11.45%
OTHER	XENAZINE	20.00%
OTHER	XEOMIN	11.45%
OTHER	XGEVA	20.00%
OTHER	XIAFLEX	11.45%
OTHER	XYREM	20.00%
OTHER	ZEMPLAR	11.45%
OTHER	ZEMPLAR	20.00%
OTHER	ZOMETA	11.45%
OTHER - IMMUNOMODULATOR	AZASAN	20.00%
OTHER - IMMUNOMODULATOR	IMURAN	20.00%

OTHER - IMMUNOMODULATOR	OTREXUP	11.45%
OTHER - IMMUNOMODULATOR	OTREXUP	20.00%
OTHER - IMMUNOMODULATOR	RASUVO	20.00%
OTHER - IMMUNOMODULATOR	RHEUMATREX	20.00%
OTHER - IMMUNOMODULATOR	THERACYS	11.45%
OTHER - IMMUNOMODULATOR	TREXALL	20.00%
PARKINSON'S DISEASE	APOKYN	20.00%
PARKINSON'S DISEASE	DUOPA	15.00%
PKU	KUVAN	20.00%
PROTEIN C DEFICIENCY	CEPROTIN	11.45%
PSORIASIS	COSENTYX	20.00%
PSORIASIS	STELARA	20.00%
PULMONARY ARTERIAL HYPERTENSION	ADCIRCA	20.00%
PULMONARY ARTERIAL HYPERTENSION	ADEMPAS	20.00%
PULMONARY ARTERIAL HYPERTENSION	FLOLAN	11.45%
PULMONARY ARTERIAL HYPERTENSION	LETAIRIS	20.00%
PULMONARY ARTERIAL HYPERTENSION	OPSUMIT	20.00%
PULMONARY ARTERIAL HYPERTENSION	ORENITRAM ER	20.00%
PULMONARY ARTERIAL HYPERTENSION	REMODULIN	11.45%
PULMONARY ARTERIAL HYPERTENSION	REVATIO	11.45%

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PULMONARY ARTERIAL HYPERTENSION	REVATIO	20.00%
PULMONARY ARTERIAL HYPERTENSION	TRACLEER	20.00%
PULMONARY ARTERIAL HYPERTENSION	TYVASO	11.45%
PULMONARY ARTERIAL HYPERTENSION	UPTRAVI	20.00%
PULMONARY ARTERIAL HYPERTENSION	VELETRI	2.50%
PULMONARY ARTERIAL HYPERTENSION	VELETRI	11.45%
PULMONARY ARTERIAL HYPERTENSION	VENTAVIS	20.00%
RA	ACTEMRA	11.45%
RA	KINERET	20.00%
RA	ORENCIA	20.00%
RA	OTREXUP	20.00%
RA	XELJANZ	20.00%
RA	XELJANZ XR	20.00%
RA/IBD	CIMZIA	20.00%
RA/JIA	ORENCIA	11.45%
RA/JIA/PSOA/AS/PSORIASIS	ACTEMRA	20.00%
RA/JIA/PSOA/AS/PSORIASIS	ENBREL	20.00%
RA/JIA/PSOA/AS/PSORIASIS	ENTYVIO	11.45%
RA/JIA/PSOA/AS/PSORIASIS	OTEZLA	20.00%
RA/JIA/PSOA/AS/PSORIASIS/IBD	HUMIRA	20.00%

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RA/PSOA/AS	SIMPONI	20.00%
RA/PSOA/AS	SIMPONI ARIA	20.00%
RA/PSOA/AS/PSORIASIS/IBD	REMICADE	20.00%
RESPIRATORY SYNCYTIAL VIRUS	SYNAGIS	12.50%
RHO(D) IMMUNE GLOBULIN	HYPERRHO	11.45%
RHO(D) IMMUNE GLOBULIN	HYPERRHO S-D	11.45%
RHO(D) IMMUNE GLOBULIN	MICRHOGAM	11.45%
RHO(D) IMMUNE GLOBULIN	MICRHOGAM PLUS	11.45%
RHO(D) IMMUNE GLOBULIN	RHOGAM	11.45%
RHO(D) IMMUNE GLOBULIN	RHOGAM PLUS	11.45%
RHO(D) IMMUNE GLOBULIN	RHOPHYLAC	11.45%
RHO(D) IMMUNE GLOBULIN	WINRHO SDF	11.45%
SYSTEMIC LUPUS ERYTHEMATOSUS	BENLYSTA	11.45%
TRANSPLANT	ASTAGRAF XL	20.00%
TRANSPLANT	ATGAM	11.45%
TRANSPLANT	CELLCEPT	13.54%
TRANSPLANT	CELLCEPT	20.00%
TRANSPLANT	ENVARSUS	20.00%
TRANSPLANT	KEPIVANCE	11.45%
TRANSPLANT	MYFORTIC	20.00%

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TRANSPLANT	NEORAL	20.00%
TRANSPLANT	NULOJIX	11.45%
TRANSPLANT	PROGRAF	13.54%
TRANSPLANT	PROGRAF	20.00%
TRANSPLANT	RAPAMUNE	20.00%
TRANSPLANT	SANDIMMUNE	13.54%
TRANSPLANT	SANDIMMUNE	20.00%
TRANSPLANT	SIMULECT	11.45%
TRANSPLANT	THYMOGLOBULIN	11.45%
TRANSPLANT	ZORTRESS	20.00%
VENO-OCCLUSIVE DISEASE	DEFITELIO	20.00%

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Specialty Drug List			
Cigna HOME DELIVERY and RETAIL SPECIALTY DRUG DISCOUNTS			
GENERICS			
NDC	LABEL NAME	GENERIC NAME	AWP DISCOUNT
00378410591	ABACAVIR 300 MG TABLET	ABACAVIR SULFATE	16.00%
00904652304	ABACAVIR 300 MG TABLET	ABACAVIR SULFATE	16.00%
00904652306	ABACAVIR 300 MG TABLET	ABACAVIR SULFATE	16.00%
31722055760	ABACAVIR 300 MG TABLET	ABACAVIR SULFATE	16.00%
51079020401	ABACAVIR 300 MG TABLET	ABACAVIR SULFATE	16.00%
51079020406	ABACAVIR 300 MG TABLET	ABACAVIR SULFATE	16.00%
54569635100	ABACAVIR 300 MG TABLET	ABACAVIR SULFATE	16.00%
60505358306	ABACAVIR 300 MG TABLET	ABACAVIR SULFATE	16.00%
65862007360	ABACAVIR 300 MG TABLET	ABACAVIR SULFATE	16.00%
68084002121	ABACAVIR 300 MG TABLET	ABACAVIR SULFATE	16.00%
68180028607	ABACAVIR-LAMIVUDINE-ZIDOV TAB	ABACAVIR/LAMIVUDINE/ZIDOVUDINE	16.00%
42794000308	ADEFOVIR DIPIVOXIL 10 MG TAB	ADEFOVIR DIPIVOXIL	16.00%
47335058140	AMIFOSTINE 500 MG VIAL	AMIFOSTINE CRYSTALLINE	40.00%
47335058142	AMIFOSTINE 500 MG VIAL	AMIFOSTINE CRYSTALLINE	40.00%
55390030803	AMIFOSTINE 500 MG VIAL	AMIFOSTINE CRYSTALLINE	40.00%
00409434610	AMINOCAPROIC ACID 5 G/20 ML VL	AMINOCAPROIC ACID	53.76%
00409434673	AMINOCAPROIC ACID 5 G/20 ML VL	AMINOCAPROIC ACID	53.76%
00517912025	AMINOCAPROIC ACID 5 G/20 ML VL	AMINOCAPROIC ACID	53.76%

61748004408	AMINOCAPROIC ACID 25% SOLUTION	AMINOCAPROIC ACID	53.76%
61748004416	AMINOCAPROIC ACID 25% SOLUTION	AMINOCAPROIC ACID	53.76%
61748004501	AMINOCAPROIC ACID 500 MG TAB	AMINOCAPROIC ACID	70.94%
61748004511	AMINOCAPROIC ACID 500 MG TAB	AMINOCAPROIC ACID	70.94%
61748004601	AMINOCAPROIC ACID 1,000 MG TAB	AMINOCAPROIC ACID	21.35%
00172524060	ANAGRELIDE HCL 1 MG CAPSULE	ANAGRELIDE HCL	96.13%
00172524160	ANAGRELIDE HCL 0.5 MG CAPSULE	ANAGRELIDE HCL	94.81%
54868544302	ANAGRELIDE HCL 0.5 MG CAPSULE	ANAGRELIDE HCL	94.81%
00007440701	ARGATROBAN 250 MG/2.5 ML VIAL	ARGATROBAN	40.00%
00007440754	ARGATROBAN 250 MG/2.5 ML VIAL	ARGATROBAN	40.00%
00143967401	ARGATROBAN 250 MG/2.5 ML VIAL	ARGATROBAN	40.00%
63323052603	ARGATROBAN 250 MG/2.5 ML VIAL	ARGATROBAN	40.00%
00781325394	AZACITIDINE 100 MG VIAL	AZACITIDINE	16.71%
00781925394	AZACITIDINE 100 MG VIAL	AZACITIDINE	16.71%
43598030562	AZACITIDINE 100 MG VIAL	AZACITIDINE	16.71%
67457025430	AZACITIDINE 100 MG VIAL	AZACITIDINE	16.71%
00054408425	AZATHIOPRINE 50 MG TABLET	AZATHIOPRINE	75.00%
00054808425	AZATHIOPRINE 50 MG TABLET	AZATHIOPRINE	58.29%
00378100501	AZATHIOPRINE 50 MG TABLET	AZATHIOPRINE	75.00%
21695048475	AZATHIOPRINE 50 MG TABLET	AZATHIOPRINE	58.29%
23490511009	AZATHIOPRINE 50 MG TABLET	AZATHIOPRINE	58.29%
43353068660	AZATHIOPRINE 50 MG TABLET	AZATHIOPRINE	58.29%
43353074560	AZATHIOPRINE 50 MG TABLET	AZATHIOPRINE	58.29%

51079062001	AZATHIOPRINE 50 MG TABLET	AZATHIOPRINE	58.29%
51079062006	AZATHIOPRINE 50 MG TABLET	AZATHIOPRINE	58.29%
54868531000	AZATHIOPRINE 50 MG TABLET	AZATHIOPRINE	58.29%
54868531001	AZATHIOPRINE 50 MG TABLET	AZATHIOPRINE	58.29%
54868531002	AZATHIOPRINE 50 MG TABLET	AZATHIOPRINE	58.29%
54868531003	AZATHIOPRINE 50 MG TABLET	AZATHIOPRINE	58.29%
54868531004	AZATHIOPRINE 50 MG TABLET	AZATHIOPRINE	58.29%
68084022901	AZATHIOPRINE 50 MG TABLET	AZATHIOPRINE	58.29%
68084022911	AZATHIOPRINE 50 MG TABLET	AZATHIOPRINE	58.29%
68382000301	AZATHIOPRINE 50 MG TABLET	AZATHIOPRINE	75.00%
68382000305	AZATHIOPRINE 50 MG TABLET	AZATHIOPRINE	58.29%
68462050201	AZATHIOPRINE 50 MG TABLET	AZATHIOPRINE	58.29%
69238107601	AZATHIOPRINE 50 MG TABLET	AZATHIOPRINE	16.00%
00052060202	BCG (TICE STRAIN) VIAL	BCG LIVE	40.00%
00052060302	BCG VACCINE (TICE STRAIN) VIAL	BCG VACCINE, LIVE/PF	40.00%
00378695501	BEXAROTENE 75 MG CAPSULE	BEXAROTENE	13.54%
42292000710	BEXAROTENE 75 MG CAPSULE	BEXAROTENE	13.54%
00093022001	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
00093022056	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
00378701705	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
00378701793	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
00781540901	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
00781540931	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%

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00781540964	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
00904601946	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
16714057101	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
16714057102	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
16729002301	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
16729002310	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
41616048583	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
41616048588	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
51079069201	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
51079069203	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
51991056001	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
52152052602	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
52152052630	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
54868613300	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
60429022605	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
60429022630	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
60505264201	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
60505264203	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
68084037411	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
68084037421	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
68084061211	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
68084061221	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
68382022401	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%

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68382022405	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
68382022406	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
68382022410	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE	93.48%
00703315401	BLEOMYCIN SULFATE 15 UNIT VIAL	BLEOMYCIN SULFATE	13.61%
00703315501	BLEOMYCIN SULFATE 30 UNIT VIAL	BLEOMYCIN SULFATE	11.00%
61703032322	BLEOMYCIN SULFATE 30 UNIT VIAL	BLEOMYCIN SULFATE	11.00%
61703033218	BLEOMYCIN SULFATE 15 UNIT VIAL	BLEOMYCIN SULFATE	13.61%
63323013610	BLEOMYCIN SULFATE 15 UNIT VIAL	BLEOMYCIN SULFATE	13.61%
63323013720	BLEOMYCIN SULFATE 30 UNIT VIAL	BLEOMYCIN SULFATE	11.00%
70121156701	BLEO 15K (15 UNIT USP) VIAL	BLEOMYCIN SULFATE	13.61%
00054027121	CAPECITABINE 150 MG TABLET	CAPECITABINE	19.00%
00054027223	CAPECITABINE 500 MG TABLET	CAPECITABINE	20.51%
00093747306	CAPECITABINE 150 MG TABLET	CAPECITABINE	19.00%
00093747489	CAPECITABINE 500 MG TABLET	CAPECITABINE	20.51%
16729007212	CAPECITABINE 150 MG TABLET	CAPECITABINE	19.00%
16729007329	CAPECITABINE 500 MG TABLET	CAPECITABINE	25.70%
51079051005	CAPECITABINE 500 MG TABLET	CAPECITABINE	20.51%
00703324911	CARBOPLATIN 600 MG/60 ML VIAL	CARBOPLATIN	11.00%
00703424401	CARBOPLATIN 50 MG/5 ML VIAL	CARBOPLATIN	11.00%
00703424601	CARBOPLATIN 150 MG/15 ML VIAL	CARBOPLATIN	11.00%
00703424681	CARBOPLATIN 150 MG/15 ML VIAL	CARBOPLATIN	11.00%
00703424801	CARBOPLATIN 450 MG/45 ML VIAL	CARBOPLATIN	11.00%
00703424881	CARBOPLATIN 450 MG/45 ML VIAL	CARBOPLATIN	11.00%

00703424891	CARBOPLATIN 450 MG/45 ML VIAL	CARBOPLATIN	11.00%
25021020205	CARBOPLATIN 50 MG/5 ML VIAL	CARBOPLATIN	11.00%
25021020215	CARBOPLATIN 150 MG/15 ML VIAL	CARBOPLATIN	11.00%
25021020245	CARBOPLATIN 450 MG/45 ML VIAL	CARBOPLATIN	11.00%
25021020251	CARBOPLATIN 600 MG/60 ML VIAL	CARBOPLATIN	11.00%
47335015040	CARBOPLATIN 50 MG/5 ML VIAL	CARBOPLATIN	11.00%
47335015140	CARBOPLATIN 150 MG/15 ML VIAL	CARBOPLATIN	11.00%
47335028440	CARBOPLATIN 600 MG/60 ML VIAL	CARBOPLATIN	11.00%
47335030040	CARBOPLATIN 450 MG/45 ML VIAL	CARBOPLATIN	11.00%
61703033918	CARBOPLATIN 50 MG/5 ML VIAL	CARBOPLATIN	11.00%
61703033922	CARBOPLATIN 150 MG/15 ML VIAL	CARBOPLATIN	11.00%
61703033950	CARBOPLATIN 450 MG/45 ML VIAL	CARBOPLATIN	11.00%
61703033956	CARBOPLATIN 600 MG/60 ML VIAL	CARBOPLATIN	11.00%
61703036018	CARBOPLATIN 50 MG/5 ML VIAL	CARBOPLATIN	11.00%
61703036022	CARBOPLATIN 150 MG/15 ML VIAL	CARBOPLATIN	11.00%
61703036050	CARBOPLATIN 450 MG/45 ML VIAL	CARBOPLATIN	11.00%
63323016721	CARBOPLATIN 150 MG VIAL	CARBOPLATIN	16.66%
63323017205	CARBOPLATIN 50 MG/5 ML VIAL	CARBOPLATIN	11.00%
63323017215	CARBOPLATIN 150 MG/15 ML VIAL	CARBOPLATIN	11.00%
63323017245	CARBOPLATIN 450 MG/45 ML VIAL	CARBOPLATIN	11.00%
63323017260	CARBOPLATIN 600 MG/60 ML VIAL	CARBOPLATIN	11.00%
66758004704	CARBOPLATIN 600 MG/60 ML VIAL	CARBOPLATIN	11.00%
67457049154	CARBOPLATIN 50 MG/5 ML VIAL	CARBOPLATIN	11.00%

67457049215	CARBOPLATIN 150 MG/15 ML VIAL	CARBOPLATIN	11.00%
67457049346	CARBOPLATIN 450 MG/45 ML VIAL	CARBOPLATIN	11.00%
67457049461	CARBOPLATIN 600 MG/60 ML VIAL	CARBOPLATIN	11.00%
67457060820	CARBOPLATIN 150 MG/15 ML VIAL	CARBOPLATIN	11.00%
63323002510	CHORIONIC GONAD 10,000 UNIT VL	CHORIONIC GONADOTROPIN, HUMAN	16.00%
23155021631	CIDOFOVIR 375 MG/5 ML VIAL	CIDOFOVIR	40.00%
67457021005	CIDOFOVIR 375 MG/5 ML VIAL	CIDOFOVIR	40.00%
00069008101	CISPLATIN 100 MG/100 ML VIAL	CISPLATIN	1.04%
00069008407	CISPLATIN 50 MG/50 ML VIAL	CISPLATIN	1.04%
00703574711	CISPLATIN 50 MG/50 ML VIAL	CISPLATIN	1.04%
00703574811	CISPLATIN 100 MG/100 ML VIAL	CISPLATIN	1.04%
44567050901	CISPLATIN 50 MG/50 ML VIAL	CISPLATIN	1.04%
44567051001	CISPLATIN 100 MG/100 ML VIAL	CISPLATIN	1.04%
63323010351	CISPLATIN 50 MG/50 ML VIAL	CISPLATIN	1.04%
63323010364	CISPLATIN 200 MG/200 ML VIAL	CISPLATIN	1.04%
63323010365	CISPLATIN 100 MG/100 ML VIAL	CISPLATIN	1.04%
67457042410	CISPLATIN 100 MG/100 ML VIAL	CISPLATIN	1.04%
67457042551	CISPLATIN 50 MG/50 ML VIAL	CISPLATIN	1.04%
00069008618	CLADRIBINE 10 MG/10 ML VIAL	CLADRIBINE	16.66%
00069020101	CLADRIBINE 10 MG/10 ML VIAL	CLADRIBINE	16.66%
55390011501	CLADRIBINE 10 MG/10 ML VIAL	CLADRIBINE	16.66%
55390012401	CLADRIBINE 10 MG/10 ML VIAL	CLADRIBINE	16.66%
63323014010	CLADRIBINE 10 MG/10 ML VIAL	CLADRIBINE	16.66%

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67457045010	CLADRIBINE 10 MG/10 ML VIAL	CLADRIBINE	16.66%
00054038225	CYCLOPHOSPHAMIDE 25 MG CAPSULE	CYCLOPHOSPHAMIDE	40.00%
00054038325	CYCLOPHOSPHAMIDE 50 MG CAPSULE	CYCLOPHOSPHAMIDE	40.00%
00054412925	CYCLOPHOSPHAMIDE 25 MG TAB	CYCLOPHOSPHAMIDE	17.08%
00054413025	CYCLOPHOSPHAMIDE 50 MG TABLET	CYCLOPHOSPHAMIDE	20.61%
00781323394	CYCLOPHOSPHAMIDE 500 MG VIAL	CYCLOPHOSPHAMIDE	16.66%
00781324494	CYCLOPHOSPHAMIDE 1 GM VIAL	CYCLOPHOSPHAMIDE	25.00%
00781325594	CYCLOPHOSPHAMIDE 2 GM VIAL	CYCLOPHOSPHAMIDE	16.66%
10019093501	CYCLOPHOSPHAMIDE 500 MG VIAL	CYCLOPHOSPHAMIDE	16.66%
10019093525	CYCLOPHOSPHAMIDE 500 MG VIAL	CYCLOPHOSPHAMIDE	16.66%
10019093601	CYCLOPHOSPHAMIDE 1 GM VIAL	CYCLOPHOSPHAMIDE	97.39%
10019093650	CYCLOPHOSPHAMIDE 1 GM VIAL	CYCLOPHOSPHAMIDE	97.39%
10019093701	CYCLOPHOSPHAMIDE 2 GM VIAL	CYCLOPHOSPHAMIDE	16.66%
10019093710	CYCLOPHOSPHAMIDE 2 GM VIAL	CYCLOPHOSPHAMIDE	16.66%
10019093801	CYCLOPHOSPHAMIDE 500 MG VIAL	CYCLOPHOSPHAMIDE	16.66%
10019093901	CYCLOPHOSPHAMIDE 1 GM VIAL	CYCLOPHOSPHAMIDE	97.39%
10019094201	CYCLOPHOSPHAMIDE 2 GM VIAL	CYCLOPHOSPHAMIDE	16.66%
10019094301	CYCLOPHOSPHAMIDE 500 MG VIAL	CYCLOPHOSPHAMIDE	16.66%
10019094325	CYCLOPHOSPHAMIDE 500 MG VIAL	CYCLOPHOSPHAMIDE	16.66%
10019094401	CYCLOPHOSPHAMIDE 1 GM VIAL	CYCLOPHOSPHAMIDE	97.39%
10019094450	CYCLOPHOSPHAMIDE 1 GM VIAL	CYCLOPHOSPHAMIDE	97.39%
10019094501	CYCLOPHOSPHAMIDE 2 GM VIAL	CYCLOPHOSPHAMIDE	16.66%
10019094510	CYCLOPHOSPHAMIDE 2 GM VIAL	CYCLOPHOSPHAMIDE	16.66%

10019095501	CYCLOPHOSPHAMIDE 500 MG VIAL	CYCLOPHOSPHAMIDE	16.66%
10019095550	CYCLOPHOSPHAMIDE 500 MG VIAL	CYCLOPHOSPHAMIDE	16.66%
10019095601	CYCLOPHOSPHAMIDE 1 GM VIAL	CYCLOPHOSPHAMIDE	97.39%
10019095616	CYCLOPHOSPHAMIDE 1 GM VIAL	CYCLOPHOSPHAMIDE	97.39%
10019095701	CYCLOPHOSPHAMIDE 2 GM VIAL	CYCLOPHOSPHAMIDE	16.66%
10019095711	CYCLOPHOSPHAMIDE 2 GM VIAL	CYCLOPHOSPHAMIDE	16.66%
54868500500	CYCLOPHOSPHAMIDE 50 MG TABLET	CYCLOPHOSPHAMIDE	20.61%
54868521800	CYCLOPHOSPHAMIDE 25 MG TAB	CYCLOPHOSPHAMIDE	17.08%
54868521801	CYCLOPHOSPHAMIDE 25 MG TAB	CYCLOPHOSPHAMIDE	17.08%
54868552200	CYCLOSPORINE 100 MG CAPSULE	CYCLOSPORINE	54.78%
55390012210	CYCLOSPORINE 50 MG/ML VIAL	CYCLOSPORINE	17.44%
60505013300	CYCLOSPORINE 25 MG CAPSULE	CYCLOSPORINE	17.44%
60505013400	CYCLOSPORINE 100 MG CAPSULE	CYCLOSPORINE	54.78%
68084087925	CYCLOSPORINE 25 MG CAPSULE	CYCLOSPORINE	17.44%
00074310832	GENGRAF 25 MG CAPSULE	CYCLOSPORINE, MODIFIED	16.00%
00074310932	GENGRAF 100 MG CAPSULE	CYCLOSPORINE, MODIFIED	16.00%
00074646332	GENGRAF 25 MG CAPSULE	CYCLOSPORINE, MODIFIED	16.00%
00074647932	GENGRAF 100 MG CAPSULE	CYCLOSPORINE, MODIFIED	16.00%
00074726950	GENGRAF 100 MG/ML SOLUTION	CYCLOSPORINE, MODIFIED	35.36%
00093574165	CYCLOSPORINE MODIFIED 50 MG	CYCLOSPORINE, MODIFIED	16.17%
00093574265	CYCLOSPORINE MODIFIED 100 MG	CYCLOSPORINE, MODIFIED	16.00%
00172731046	CYCLOSPORINE MODIFIED 25 MG	CYCLOSPORINE, MODIFIED	16.00%
00172731100	CYCLOSPORINE MODIFIED 50 MG	CYCLOSPORINE, MODIFIED	16.17%

00172731146	CYCLOSPORINE MODIFIED 50 MG	CYCLOSPORINE, MODIFIED	16.17%
00172731246	CYCLOSPORINE MODIFIED 100 MG	CYCLOSPORINE, MODIFIED	16.00%
00172731320	CYCLOSPORINE 100 MG/ML SOLN	CYCLOSPORINE, MODIFIED	35.36%
00185093230	CYCLOSPORINE MODIFIED 25 MG	CYCLOSPORINE, MODIFIED	16.00%
00185093330	CYCLOSPORINE MODIFIED 100 MG	CYCLOSPORINE, MODIFIED	16.00%
00591222215	CYCLOSPORINE MODIFIED 25 MG	CYCLOSPORINE, MODIFIED	16.00%
00591222315	CYCLOSPORINE MODIFIED 100 MG	CYCLOSPORINE, MODIFIED	16.00%
00591222455	CYCLOSPORINE 100 MG/ML SOLN	CYCLOSPORINE, MODIFIED	35.36%
51862045847	CYCLOSPORINE MODIFIED 25 MG	CYCLOSPORINE, MODIFIED	16.00%
51862046047	CYCLOSPORINE MODIFIED 100 MG	CYCLOSPORINE, MODIFIED	16.00%
54868623200	CYCLOSPORINE MODIFIED 100 MG	CYCLOSPORINE, MODIFIED	16.00%
60505035401	CYCLOSPORINE 100 MG/ML SOLN	CYCLOSPORINE, MODIFIED	35.36%
00069015301	CYTARABINE 500 MG/25 ML VIAL	CYTARABINE	12.00%
00069015302	CYTARABINE 500 MG/25 ML VIAL	CYTARABINE	12.00%
61703030436	CYTARABINE 20 MG/ML VIAL	CYTARABINE	12.00%
00069015201	CYTARABINE 100 MG/5 ML VIAL	CYTARABINE/PF	40.00%
00069015202	CYTARABINE 100 MG/5 ML VIAL	CYTARABINE/PF	40.00%
00069015401	CYTARABINE 1000 MG/50 ML VIAL	CYTARABINE/PF	40.00%
00069015501	CYTARABINE 2 G/20 ML VIAL	CYTARABINE/PF	6.05%
55390013110	CYTARABINE 100 MG VIAL	CYTARABINE/PF	10.97%
55390013210	CYTARABINE 500 MG VIAL	CYTARABINE/PF	40.00%
55390013301	CYTARABINE 1 GM VIAL	CYTARABINE/PF	40.00%
55390080610	CYTARABINE 100 MG VIAL	CYTARABINE/PF	10.97%

55390080710	CYTARABINE 500 MG VIAL	CYTARABINE/PF	40.00%
55390080801	CYTARABINE 1 GM VIAL	CYTARABINE/PF	40.00%
61703030346	CYTARABINE 20 MG/ML VIAL	CYTARABINE/PF	40.00%
61703030538	CYTARABINE 20 MG/ML VIAL	CYTARABINE/PF	40.00%
61703031922	CYTARABINE 2 G/20 ML VIAL	CYTARABINE/PF	6.05%
63323012020	CYTARABINE 2 G/20 ML VIAL	CYTARABINE/PF	6.05%
67457045220	CYTARABINE 2 G/20 ML VIAL	CYTARABINE/PF	6.05%
67457045450	CYTARABINE 1000 MG/50 ML VIAL	CYTARABINE/PF	40.00%
67457045552	CYTARABINE 100 MG/5 ML VIAL	CYTARABINE/PF	40.00%
00703507501	DACARBAZINE 200 MG VIAL	DACARBAZINE	40.00%
00703507503	DACARBAZINE 200 MG VIAL	DACARBAZINE	40.00%
55390009010	DACARBAZINE 200 MG VIAL	DACARBAZINE	40.00%
61703032722	DACARBAZINE 200 MG VIAL	DACARBAZINE	40.00%
63323012710	DACARBAZINE 100 MG VIAL	DACARBAZINE	40.00%
63323012820	DACARBAZINE 200 MG VIAL	DACARBAZINE	40.00%
00703523313	DAUNORUBICIN 20 MG/4 ML VIAL	DAUNORUBICIN HCL	40.00%
00703523393	DAUNORUBICIN 20 MG/4 ML VIAL	DAUNORUBICIN HCL	40.00%
55390010801	DAUNORUBICIN 50 MG/10 ML VIAL	DAUNORUBICIN HCL	40.00%
55390010810	DAUNORUBICIN 20 MG/4 ML VIAL	DAUNORUBICIN HCL	40.00%
55390014210	DAUNORUBICIN 20 MG/4 ML VIAL	DAUNORUBICIN HCL	40.00%
63323011908	DAUNORUBICIN 20 MG VIAL	DAUNORUBICIN HCL	40.00%
00781313980	DECITABINE 50 MG VIAL	DECITABINE	21.00%
43598034837	DECITABINE 50 MG VIAL	DECITABINE	21.00%

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43598042737	DECITABINE 50 MG VIAL	DECITABINE	21.00%
47335036141	DECITABINE 50 MG VIAL	DECITABINE	21.00%
55111055610	DECITABINE 50 MG VIAL	DECITABINE	21.00%
00409226501	DESMOPRESSIN AC 4 MCG/ML AMPUL	DESMOPRESSIN ACETATE	15.00%
00703505101	DESMOPRESSIN AC 4 MCG/ML VIAL	DESMOPRESSIN ACETATE	15.00%
00703505103	DESMOPRESSIN AC 4 MCG/ML VIAL	DESMOPRESSIN ACETATE	15.00%
00703505401	DESMOPRESSIN AC 4 MCG/ML VIAL	DESMOPRESSIN ACETATE	15.00%
55566503001	DESMOPRESSIN AC 4 MCG/ML AMPUL	DESMOPRESSIN ACETATE	15.00%
55566504001	DESMOPRESSIN AC 4 MCG/ML VIAL	DESMOPRESSIN ACETATE	15.00%
62756052926	DESMOPRESSIN 40 MCG/10 ML VIAL	DESMOPRESSIN ACETATE	15.00%
62756052940	DESMOPRESSIN 40 MCG/10 ML VIAL	DESMOPRESSIN ACETATE	15.00%
69918090110	DESMOPRESSIN AC 4 MCG/ML VIAL	DESMOPRESSIN ACETATE	15.00%
00378888693	DIDANOSINE DR 125 MG CAPSULE	DIDANOSINE	16.00%
00378888793	DIDANOSINE DR 200 MG CAPSULE	DIDANOSINE	16.00%
00378888893	DIDANOSINE DR 250 MG CAPSULE	DIDANOSINE	16.00%
00378888993	DIDANOSINE DR 400 MG CAPSULE	DIDANOSINE	16.00%
00555058801	DIDANOSINE DR 200 MG CAPSULE	DIDANOSINE	16.00%
00555058901	DIDANOSINE DR 250 MG CAPSULE	DIDANOSINE	16.00%
00555059001	DIDANOSINE DR 400 MG CAPSULE	DIDANOSINE	16.00%
35356025930	DIDANOSINE DR 400 MG CAPSULE	DIDANOSINE	16.00%
54569564200	DIDANOSINE DR 250 MG CAPSULE	DIDANOSINE	16.00%
54569564300	DIDANOSINE DR 400 MG CAPSULE	DIDANOSINE	16.00%
54868546400	DIDANOSINE DR 250 MG CAPSULE	DIDANOSINE	16.00%

65862031030	DIDANOSINE DR 125 MG CAPSULE	DIDANOSINE	16.00%
65862031130	DIDANOSINE DR 200 MG CAPSULE	DIDANOSINE	16.00%
65862031230	DIDANOSINE DR 250 MG CAPSULE	DIDANOSINE	16.00%
65862031330	DIDANOSINE DR 400 MG CAPSULE	DIDANOSINE	16.00%
00069914111	DOCETAXEL 20 MG/2 ML VIAL	DOCETAXEL	40.00%
00069914122	DOCETAXEL 20 MG/2 ML VIAL	DOCETAXEL	40.00%
00069914211	DOCETAXEL 80 MG/8 ML VIAL	DOCETAXEL	40.00%
00069914222	DOCETAXEL 80 MG/8 ML VIAL	DOCETAXEL	40.00%
00069914411	DOCETAXEL 200 MG/20 ML VIAL	DOCETAXEL	21.00%
00409020102	DOCETAXEL 20 MG/2 ML VIAL	DOCETAXEL	40.00%
00409020110	DOCETAXEL 80 MG/8 ML VIAL	DOCETAXEL	40.00%
00409020120	DOCETAXEL 160 MG/16 ML VIAL	DOCETAXEL	40.00%
00409020125	DOCETAXEL 20 MG/2 ML VIAL	DOCETAXEL	40.00%
00409020126	DOCETAXEL 80 MG/8 ML VIAL	DOCETAXEL	40.00%
00409020127	DOCETAXEL 160 MG/16 ML VIAL	DOCETAXEL	40.00%
00955102001	DOCETAXEL 20 MG/ML VIAL	DOCETAXEL	21.00%
00955102104	DOCETAXEL 80 MG/4 ML VIAL	DOCETAXEL	40.00%
16729012049	DOCETAXEL 20 MG/0.5 ML VIAL	DOCETAXEL	40.00%
16729022850	DOCETAXEL 80 MG/2 ML VIAL	DOCETAXEL	40.00%
16729023163	DOCETAXEL 20 MG/ML VIAL	DOCETAXEL	21.00%
16729023164	DOCETAXEL 80 MG/4 ML VIAL	DOCETAXEL	40.00%
16729023165	DOCETAXEL 160 MG/8 ML VIAL	DOCETAXEL	40.00%
16729026763	DOCETAXEL 20 MG/ML VIAL	DOCETAXEL	21.00%

16729026764	DOCETAXEL 80 MG/4 ML VIAL	DOCETAXEL	40.00%
16729026765	DOCETAXEL 160 MG/8 ML VIAL	DOCETAXEL	40.00%
25021022201	DOCETAXEL 20 MG/ML VIAL	DOCETAXEL	21.00%
25021022204	DOCETAXEL 80 MG/4 ML VIAL	DOCETAXEL	40.00%
25021022207	DOCETAXEL 140 MG/7 ML VIAL	DOCETAXEL	40.00%
42367012121	DOCETAXEL 20 MG/ML VIAL	DOCETAXEL	21.00%
42367012125	DOCETAXEL 80 MG/4 ML VIAL	DOCETAXEL	40.00%
42367012129	DOCETAXEL 160 MG/8 ML VIAL	DOCETAXEL	40.00%
43598025811	DOCETAXEL 20 MG/ML VIAL	DOCETAXEL	21.00%
43598025940	DOCETAXEL 80 MG/4 ML VIAL	DOCETAXEL	40.00%
45963073452	DOCETAXEL 80 MG/4 ML VIAL	DOCETAXEL	40.00%
45963073454	DOCETAXEL 20 MG/ML VIAL	DOCETAXEL	21.00%
45963073474	DOCETAXEL 140 MG/7 ML VIAL	DOCETAXEL	40.00%
45963079056	DOCETAXEL 160 MG/8 ML VIAL	DOCETAXEL	40.00%
60505603506	DOCETAXEL 20 MG/0.5 ML VIAL	DOCETAXEL	40.00%
60505603706	DOCETAXEL 80 MG/2 ML VIAL	DOCETAXEL	40.00%
63739093211	DOCETAXEL 20 MG/ML VIAL	DOCETAXEL	21.00%
63739097117	DOCETAXEL 80 MG/4 ML VIAL	DOCETAXEL	40.00%
66758005001	DOCETAXEL 20 MG/2 ML VIAL	DOCETAXEL	40.00%
66758005002	DOCETAXEL 80 MG/8 ML VIAL	DOCETAXEL	40.00%
66758005003	DOCETAXEL 160 MG/16 ML VIAL	DOCETAXEL	40.00%
00069017001	DOXORUBICIN 10 MG VIAL	DOXORUBICIN HCL	11.45%
00069017101	DOXORUBICIN 50 MG VIAL	DOXORUBICIN HCL	42.00%

00069303020	DOXORUBICIN 10 MG/5 ML VIAL	DOXORUBICIN HCL	15.00%
00069303120	DOXORUBICIN 20 MG/10 ML VIAL	DOXORUBICIN HCL	15.00%
00069303220	DOXORUBICIN 50 MG/25 ML VIAL	DOXORUBICIN HCL	15.00%
00069303320	DOXORUBICIN 150 MG/75 ML VIAL	DOXORUBICIN HCL	15.00%
00069303420	DOXORUBICIN 200 MG/100 ML VIAL	DOXORUBICIN HCL	15.00%
00069400405	DOXORUBICIN 10 MG/5 ML VIAL	DOXORUBICIN HCL	15.00%
00069401510	DOXORUBICIN 20 MG/10 ML VIAL	DOXORUBICIN HCL	15.00%
00069402625	DOXORUBICIN 50 MG/25 ML VIAL	DOXORUBICIN HCL	15.00%
00069403001	DOXORUBICIN 10 MG/5 ML VIAL	DOXORUBICIN HCL	15.00%
00069403101	DOXORUBICIN 20 MG/10 ML VIAL	DOXORUBICIN HCL	15.00%
00069403201	DOXORUBICIN 50 MG/25 ML VIAL	DOXORUBICIN HCL	15.00%
00069403301	DOXORUBICIN 150 MG/75 ML VIAL	DOXORUBICIN HCL	15.00%
00069403401	DOXORUBICIN 200 MG/100 ML VIAL	DOXORUBICIN HCL	15.00%
00069403701	DOXORUBICIN 200 MG/100 ML VIAL	DOXORUBICIN HCL	15.00%
00703504001	DOXORUBICIN 200 MG/100 ML VIAL	DOXORUBICIN HCL	15.00%
00703504303	DOXORUBICIN 10 MG/5 ML VIAL	DOXORUBICIN HCL	15.00%
00703504601	DOXORUBICIN 50 MG/25 ML VIAL	DOXORUBICIN HCL	15.00%
25021020705	DOXORUBICIN 10 MG/5 ML VIAL	DOXORUBICIN HCL	15.00%
25021020725	DOXORUBICIN 50 MG/25 ML VIAL	DOXORUBICIN HCL	15.00%
25021020751	DOXORUBICIN 200 MG/100 ML VIAL	DOXORUBICIN HCL	15.00%
45963073355	DOXORUBICIN 10 MG/5 ML VIAL	DOXORUBICIN HCL	15.00%
45963073357	DOXORUBICIN 20 MG/10 ML VIAL	DOXORUBICIN HCL	15.00%
45963073360	DOXORUBICIN 200 MG/100 ML VIAL	DOXORUBICIN HCL	15.00%

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45963073368	DOXORUBICIN 50 MG/25 ML VIAL	DOXORUBICIN HCL	15.00%
47335004940	DOXORUBICIN LIPOSOME 20MG/10ML	DOXORUBICIN HCL	15.00%
47335005040	DOXORUBICIN LIPOSOME 50MG/25ML	DOXORUBICIN HCL	15.00%
53150031410	DOXORUBICIN 20 MG/10 ML VIAL	DOXORUBICIN HCL	15.00%
53150031501	DOXORUBICIN 50 MG/25 ML VIAL	DOXORUBICIN HCL	15.00%
53150031701	DOXORUBICIN 200 MG/100 ML VIAL	DOXORUBICIN HCL	15.00%
53150032010	DOXORUBICIN 10 MG/5 ML VIAL	DOXORUBICIN HCL	15.00%
55390023110	ADRIAMYCIN 10 MG VIAL	DOXORUBICIN HCL	11.45%
55390023210	ADRIAMYCIN 20 MG VIAL	DOXORUBICIN HCL	16.00%
55390023510	ADRIAMYCIN 2 MG/ML VIAL	DOXORUBICIN HCL	15.00%
55390023610	ADRIAMYCIN 2 MG/ML VIAL	DOXORUBICIN HCL	15.00%
55390023701	ADRIAMYCIN 2 MG/ML VIAL	DOXORUBICIN HCL	15.00%
55390023801	ADRIAMYCIN 200 MG/100 ML VIAL	DOXORUBICIN HCL	15.00%
55390024110	DOXORUBICIN 10 MG VIAL	DOXORUBICIN HCL	11.45%
55390024510	DOXORUBICIN 10 MG/5 ML VIAL	DOXORUBICIN HCL	15.00%
55390024610	DOXORUBICIN 20 MG/10 ML VIAL	DOXORUBICIN HCL	15.00%
55390024701	DOXORUBICIN 50 MG/25 ML VIAL	DOXORUBICIN HCL	15.00%
55390024801	DOXORUBICIN 200 MG/100 ML VIAL	DOXORUBICIN HCL	15.00%
62756082640	DOXORUBICIN 50 MG/25 ML VIAL	DOXORUBICIN HCL	15.00%
62756082740	DOXORUBICIN 200 MG/100 ML VIAL	DOXORUBICIN HCL	15.00%
63323010161	DOXORUBICIN 200 MG/100 ML VIAL	DOXORUBICIN HCL	15.00%
63323088305	DOXORUBICIN 10 MG/5 ML VIAL	DOXORUBICIN HCL	15.00%

63323088310	DOXORUBICIN 20 MG/10 ML VIAL	DOXORUBICIN HCL	15.00%
63323088330	DOXORUBICIN 50 MG/25 ML VIAL	DOXORUBICIN HCL	15.00%
67457039354	DOXORUBICIN 10 MG/5 ML VIAL	DOXORUBICIN HCL	15.00%
67457039410	DOXORUBICIN 20 MG/10 ML VIAL	DOXORUBICIN HCL	15.00%
67457039525	DOXORUBICIN 50 MG/25 ML VIAL	DOXORUBICIN HCL	15.00%
67457039610	DOXORUBICIN 200 MG/100 ML VIAL	DOXORUBICIN HCL	15.00%
67457043650	DOXORUBICIN 50 MG VIAL	DOXORUBICIN HCL	42.00%
67457047810	DOXORUBICIN 10 MG VIAL	DOXORUBICIN HCL	11.45%
47335008250	LIPODOX 2 MG/ML VIAL	DOXORUBICIN HCL LIPOSOMAL	21.00%
47335008350	LIPODOX 50 2 MG/ML VIAL	DOXORUBICIN HCL LIPOSOMAL	21.00%
00548560100	ENOXAPARIN 30 MG/0.3 ML SYR	ENOXAPARIN SODIUM	33.51%
00548560200	ENOXAPARIN 40 MG/0.4 ML SYR	ENOXAPARIN SODIUM	48.61%
00548560300	ENOXAPARIN 60 MG/0.6 ML SYR	ENOXAPARIN SODIUM	50.74%
00548560400	ENOXAPARIN 80 MG/0.8 ML SYR	ENOXAPARIN SODIUM	49.90%
00548560500	ENOXAPARIN 100 MG/ML SYRINGE	ENOXAPARIN SODIUM	56.14%
00548560600	ENOXAPARIN 120 MG/0.8 ML SYR	ENOXAPARIN SODIUM	57.53%
00548560700	ENOXAPARIN 150 MG/ML SYRINGE	ENOXAPARIN SODIUM	61.90%
00548563100	ENOXAPARIN 30 MG/0.3 ML SYR	ENOXAPARIN SODIUM	33.51%
00548563200	ENOXAPARIN 40 MG/0.4 ML SYR	ENOXAPARIN SODIUM	48.61%
00548563300	ENOXAPARIN 60 MG/0.6 ML SYR	ENOXAPARIN SODIUM	50.74%
00548563400	ENOXAPARIN 80 MG/0.8 ML SYR	ENOXAPARIN SODIUM	49.90%
00548563500	ENOXAPARIN 100 MG/ML SYRINGE	ENOXAPARIN SODIUM	56.14%
00548563600	ENOXAPARIN 120 MG/0.8 ML SYR	ENOXAPARIN SODIUM	57.53%

00548563700	ENOXAPARIN 150 MG/ML SYRINGE	ENOXAPARIN SODIUM	61.90%
00703851021	ENOXAPARIN 150 MG/ML SYRINGE	ENOXAPARIN SODIUM	61.90%
00703851023	ENOXAPARIN 150 MG/ML SYRINGE	ENOXAPARIN SODIUM	61.90%
00703853021	ENOXAPARIN 30 MG/0.3 ML SYR	ENOXAPARIN SODIUM	33.51%
00703853023	ENOXAPARIN 30 MG/0.3 ML SYR	ENOXAPARIN SODIUM	33.51%
00703854021	ENOXAPARIN 40 MG/0.4 ML SYR	ENOXAPARIN SODIUM	48.61%
00703854023	ENOXAPARIN 40 MG/0.4 ML SYR	ENOXAPARIN SODIUM	48.61%
00703856021	ENOXAPARIN 60 MG/0.6 ML SYR	ENOXAPARIN SODIUM	50.74%
00703856023	ENOXAPARIN 60 MG/0.6 ML SYR	ENOXAPARIN SODIUM	50.74%
00703858021	ENOXAPARIN 100 MG/ML SYRINGE	ENOXAPARIN SODIUM	56.14%
00703858023	ENOXAPARIN 100 MG/ML SYRINGE	ENOXAPARIN SODIUM	56.14%
00703861021	ENOXAPARIN 120 MG/0.8 ML SYR	ENOXAPARIN SODIUM	57.53%
00703861023	ENOXAPARIN 120 MG/0.8 ML SYR	ENOXAPARIN SODIUM	57.53%
00703868021	ENOXAPARIN 80 MG/0.8 ML SYR	ENOXAPARIN SODIUM	49.90%
00703868023	ENOXAPARIN 80 MG/0.8 ML SYR	ENOXAPARIN SODIUM	49.90%
00781312293	ENOXAPARIN 300 MG/3 ML VIAL	ENOXAPARIN SODIUM	19.00%
00781313301	ENOXAPARIN 30 MG/0.3 ML SYR	ENOXAPARIN SODIUM	33.51%
00781313363	ENOXAPARIN 30 MG/0.3 ML SYR	ENOXAPARIN SODIUM	33.51%
00781322402	ENOXAPARIN 40 MG/0.4 ML SYR	ENOXAPARIN SODIUM	48.61%
00781322464	ENOXAPARIN 40 MG/0.4 ML SYR	ENOXAPARIN SODIUM	48.61%
00781335603	ENOXAPARIN 60 MG/0.6 ML SYR	ENOXAPARIN SODIUM	50.74%
00781335666	ENOXAPARIN 60 MG/0.6 ML SYR	ENOXAPARIN SODIUM	50.74%
00781342804	ENOXAPARIN 80 MG/0.8 ML SYR	ENOXAPARIN SODIUM	49.90%

00781342868	ENOXAPARIN 80 MG/0.8 ML SYR	ENOXAPARIN SODIUM	49.90%
00781350005	ENOXAPARIN 100 MG/ML SYRINGE	ENOXAPARIN SODIUM	56.14%
00781350069	ENOXAPARIN 100 MG/ML SYRINGE	ENOXAPARIN SODIUM	56.14%
00781361204	ENOXAPARIN 120 MG/0.8 ML SYR	ENOXAPARIN SODIUM	57.53%
00781361268	ENOXAPARIN 120 MG/0.8 ML SYR	ENOXAPARIN SODIUM	57.53%
00781365505	ENOXAPARIN 150 MG/ML SYRINGE	ENOXAPARIN SODIUM	61.90%
00781365569	ENOXAPARIN 150 MG/ML SYRINGE	ENOXAPARIN SODIUM	61.90%
00955100310	ENOXAPARIN 30 MG/0.3 ML SYR	ENOXAPARIN SODIUM	33.51%
00955100410	ENOXAPARIN 40 MG/0.4 ML SYR	ENOXAPARIN SODIUM	48.61%
00955100610	ENOXAPARIN 60 MG/0.6 ML SYR	ENOXAPARIN SODIUM	50.74%
00955100810	ENOXAPARIN 80 MG/0.8 ML SYR	ENOXAPARIN SODIUM	49.90%
00955101010	ENOXAPARIN 100 MG/ML SYRINGE	ENOXAPARIN SODIUM	56.14%
00955101210	ENOXAPARIN 120 MG/0.8 ML SYR	ENOXAPARIN SODIUM	57.53%
00955101510	ENOXAPARIN 150 MG/ML SYRINGE	ENOXAPARIN SODIUM	61.90%
00955101601	ENOXAPARIN 300 MG/3 ML VIAL	ENOXAPARIN SODIUM	19.00%
62037083920	ENOXAPARIN 30 MG/0.3 ML SYR	ENOXAPARIN SODIUM	33.51%
62037084920	ENOXAPARIN 40 MG/0.4 ML SYR	ENOXAPARIN SODIUM	48.61%
62037086120	ENOXAPARIN 60 MG/0.6 ML SYR	ENOXAPARIN SODIUM	50.74%
62037086220	ENOXAPARIN 80 MG/0.8 ML SYR	ENOXAPARIN SODIUM	49.90%
62037086320	ENOXAPARIN 100 MG/ML SYRINGE	ENOXAPARIN SODIUM	56.14%
62037086420	ENOXAPARIN 120 MG/0.8 ML SYR	ENOXAPARIN SODIUM	57.53%
62037086620	ENOXAPARIN 150 MG/ML SYRINGE	ENOXAPARIN SODIUM	61.90%
63323056586	ENOXAPARIN 300 MG/3 ML VIAL	ENOXAPARIN SODIUM	19.00%

63323056883	ENOXAPARIN 30 MG/0.3 ML SYR	ENOXAPARIN SODIUM	33.51%
63323056884	ENOXAPARIN 100 MG/ML SYRINGE	ENOXAPARIN SODIUM	56.14%
63323056887	ENOXAPARIN 40 MG/0.4 ML SYR	ENOXAPARIN SODIUM	48.61%
63323056888	ENOXAPARIN 60 MG/0.6 ML SYR	ENOXAPARIN SODIUM	50.74%
63323056890	ENOXAPARIN 80 MG/0.8 ML SYR	ENOXAPARIN SODIUM	49.90%
63323056984	ENOXAPARIN 150 MG/ML SYRINGE	ENOXAPARIN SODIUM	61.90%
63323056990	ENOXAPARIN 120 MG/0.8 ML SYR	ENOXAPARIN SODIUM	57.53%
00093578656	ENTECAVIR 0.5 MG TABLET	ENTECAVIR	40.00%
00093578698	ENTECAVIR 0.5 MG TABLET	ENTECAVIR	40.00%
00093578756	ENTECAVIR 1 MG TABLET	ENTECAVIR	40.00%
10135061630	ENTECAVIR 1 MG TABLET	ENTECAVIR	40.00%
31722083330	ENTECAVIR 0.5 MG TABLET	ENTECAVIR	40.00%
31722083390	ENTECAVIR 0.5 MG TABLET	ENTECAVIR	40.00%
31722083430	ENTECAVIR 1 MG TABLET	ENTECAVIR	40.00%
49884010411	ENTECAVIR 0.5 MG TABLET	ENTECAVIR	40.00%
49884010511	ENTECAVIR 1 MG TABLET	ENTECAVIR	40.00%
65162044603	ENTECAVIR 0.5 MG TABLET	ENTECAVIR	40.00%
65162044903	ENTECAVIR 1 MG TABLET	ENTECAVIR	40.00%
65862084130	ENTECAVIR 0.5 MG TABLET	ENTECAVIR	40.00%
65862084190	ENTECAVIR 0.5 MG TABLET	ENTECAVIR	40.00%
65862084230	ENTECAVIR 1 MG TABLET	ENTECAVIR	40.00%
00703306711	EPIRUBICIN 50 MG/25 ML VIAL	EPIRUBICIN HCL	40.00%
00703306911	EPIRUBICIN 200 MG/100 ML VIAL	EPIRUBICIN HCL	40.00%

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25021020325	EPIRUBICIN 50 MG/25 ML VIAL	EPIRUBICIN HCL	40.00%
25021020351	EPIRUBICIN 200 MG/100 ML VIAL	EPIRUBICIN HCL	40.00%
45963060860	EPIRUBICIN 200 MG/100 ML VIAL	EPIRUBICIN HCL	40.00%
45963060868	EPIRUBICIN 50 MG/25 ML VIAL	EPIRUBICIN HCL	40.00%
53150024701	EPIRUBICIN 200 MG/100 ML VIAL	EPIRUBICIN HCL	40.00%
53150025001	EPIRUBICIN 50 MG/25 ML VIAL	EPIRUBICIN HCL	40.00%
59762509101	EPIRUBICIN 50 MG/25 ML VIAL	EPIRUBICIN HCL	40.00%
59762509301	EPIRUBICIN 200 MG/100 ML VIAL	EPIRUBICIN HCL	40.00%
59923070100	EPIRUBICIN 200 MG/100 ML VIAL	EPIRUBICIN HCL	40.00%
59923070125	EPIRUBICIN 50 MG/25 ML VIAL	EPIRUBICIN HCL	40.00%
61703034735	EPIRUBICIN HCL 50 MG VIAL	EPIRUBICIN HCL	40.00%
61703034859	EPIRUBICIN HCL 200 MG VIAL	EPIRUBICIN HCL	40.00%
61703035901	EPIRUBICIN 50 MG/25 ML VIAL	EPIRUBICIN HCL	40.00%
61703035902	EPIRUBICIN 200 MG/100 ML VIAL	EPIRUBICIN HCL	40.00%
61703035959	EPIRUBICIN 200 MG/100 ML VIAL	EPIRUBICIN HCL	40.00%
61703035993	EPIRUBICIN 50 MG/25 ML VIAL	EPIRUBICIN HCL	40.00%
63323015100	EPIRUBICIN 200 MG/100 ML VIAL	EPIRUBICIN HCL	40.00%
63323015125	EPIRUBICIN 50 MG/25 ML VIAL	EPIRUBICIN HCL	40.00%
66758004201	EPIRUBICIN 50 MG/25 ML VIAL	EPIRUBICIN HCL	40.00%
66758004202	EPIRUBICIN 200 MG/100 ML VIAL	EPIRUBICIN HCL	40.00%
00703198501	EPOPROSTENOL SODIUM 0.5 MG VL	EPOPROSTENOL SODIUM	40.00%
00703199501	EPOPROSTENOL SODIUM 1.5 MG VL	EPOPROSTENOL SODIUM	40.00%
00378326694	ETOPOSIDE 50 MG CAPSULE	ETOPOSIDE	15.00%

00703565301	TOPOSAR 100 MG/5 ML VIAL	ETOPOSIDE	30.55%
00703565601	TOPOSAR 500 MG/25 ML VIAL	ETOPOSIDE	30.55%
00703565691	TOPOSAR 500 MG/25 ML VIAL	ETOPOSIDE	30.55%
00703565701	TOPOSAR 1,000 MG/50 ML VIAL	ETOPOSIDE	30.55%
00703565791	TOPOSAR 1,000 MG/50 ML VIAL	ETOPOSIDE	30.55%
16729011431	ETOPOSIDE 100 MG/5 ML VIAL	ETOPOSIDE	30.55%
16729026231	ETOPOSIDE 100 MG/5 ML VIAL	ETOPOSIDE	30.55%
55390029101	ETOPOSIDE 100 MG/5 ML VIAL	ETOPOSIDE	30.55%
55390029201	ETOPOSIDE 500 MG/25 ML VIAL	ETOPOSIDE	30.55%
55390029301	ETOPOSIDE 1,000 MG/50 ML VIAL	ETOPOSIDE	30.55%
55390049101	ETOPOSIDE 100 MG/5 ML VIAL	ETOPOSIDE	30.55%
55390049201	ETOPOSIDE 500 MG/25 ML VIAL	ETOPOSIDE	30.55%
55390049301	ETOPOSIDE 1,000 MG/50 ML VIAL	ETOPOSIDE	30.55%
63323010405	ETOPOSIDE 100 MG/5 ML VIAL	ETOPOSIDE	30.55%
63323010425	ETOPOSIDE 500 MG/25 ML VIAL	ETOPOSIDE	30.55%
63323010450	ETOPOSIDE 1,000 MG/50 ML VIAL	ETOPOSIDE	30.55%
68001026525	ETOPOSIDE 100 MG/5 ML VIAL	ETOPOSIDE	30.55%
68001026526	ETOPOSIDE 500 MG/25 ML VIAL	ETOPOSIDE	30.55%
68001026527	ETOPOSIDE 1,000 MG/50 ML VIAL	ETOPOSIDE	30.55%
55390013501	FLOXURIDINE 500 MG VIAL	FLOXURIDINE	40.00%
63323014507	FLOXURIDINE 500 MG VIAL	FLOXURIDINE	40.00%
00069932122	FLUDARABINE 50 MG/2 ML VIAL	FLUDARABINE PHOSPHATE	40.00%
00703485211	FLUDARABINE 50 MG/2 ML VIAL	FLUDARABINE PHOSPHATE	40.00%

00703585401	FLUDARABINE 50 MG VIAL	FLUDARABINE PHOSPHATE	40.00%
25021020505	FLUDARABINE 50 MG VIAL	FLUDARABINE PHOSPHATE	40.00%
25021023706	FLUDARABINE 50 MG VIAL	FLUDARABINE PHOSPHATE	40.00%
45963060955	FLUDARABINE 50 MG VIAL	FLUDARABINE PHOSPHATE	40.00%
61703034418	FLUDARABINE 50 MG VIAL	FLUDARABINE PHOSPHATE	40.00%
63323019202	FLUDARABINE 50 MG/2 ML VIAL	FLUDARABINE PHOSPHATE	40.00%
63323019606	FLUDARABINE 50 MG VIAL	FLUDARABINE PHOSPHATE	40.00%
66758004601	FLUDARABINE 50 MG/2 ML VIAL	FLUDARABINE PHOSPHATE	40.00%
67457023802	FLUDARABINE 50 MG/2 ML VIAL	FLUDARABINE PHOSPHATE	40.00%
00703301513	ADRUCIL 500 MG/10 ML VIAL	FLUOROURACIL	19.18%
00703301812	ADRUCIL 2,500 MG/50 ML VIAL	FLUOROURACIL	14.00%
00703301912	ADRUCIL 5 GRAM/100 ML VIAL	FLUOROURACIL	19.62%
10139006301	FLUOROURACIL 5,000 MG/100 ML	FLUOROURACIL	19.62%
10139006310	FLUOROURACIL 500 MG/10 ML VIAL	FLUOROURACIL	19.18%
10139006311	FLUOROURACIL 500 MG/10 ML VIAL	FLUOROURACIL	19.18%
10139006312	FLUOROURACIL 1,000 MG/20 ML VL	FLUOROURACIL	16.66%
10139006320	FLUOROURACIL 1,000 MG/20 ML VL	FLUOROURACIL	16.66%
10139006350	FLUOROURACIL 2,500 MG/50 ML VL	FLUOROURACIL	14.00%
16729027611	FLUOROURACIL 2,500 MG/50 ML VL	FLUOROURACIL	14.00%
16729027638	FLUOROURACIL 5,000 MG/100 ML	FLUOROURACIL	19.62%
16729027667	FLUOROURACIL 1,000 MG/20 ML VL	FLUOROURACIL	16.66%
16729027668	FLUOROURACIL 500 MG/10 ML VIAL	FLUOROURACIL	19.18%
63323011710	FLUOROURACIL 500 MG/10 ML VIAL	FLUOROURACIL	19.18%

63323011718	FLUOROURACIL 500 MG/10 ML VIAL	FLUOROURACIL	19.18%
63323011719	FLUOROURACIL 500 MG/10 ML VIAL	FLUOROURACIL	19.18%
63323011720	FLUOROURACIL 1,000 MG/20 ML VL	FLUOROURACIL	16.66%
63323011728	FLUOROURACIL 1,000 MG/20 ML VL	FLUOROURACIL	16.66%
63323011751	FLUOROURACIL 2,500 MG/50 ML VL	FLUOROURACIL	14.00%
63323011758	FLUOROURACIL 2,500 MG/50 ML VL	FLUOROURACIL	14.00%
63323011759	FLUOROURACIL 2,500 MG/50 ML VL	FLUOROURACIL	14.00%
63323011761	FLUOROURACIL 5,000 MG/100 ML	FLUOROURACIL	19.62%
63323011768	FLUOROURACIL 5,000 MG/100 ML	FLUOROURACIL	19.62%
63323011769	FLUOROURACIL 5,000 MG/100 ML	FLUOROURACIL	19.62%
68001026627	FLUOROURACIL 2.5 GM/50 ML VIAL	FLUOROURACIL	14.00%
68001026630	FLUOROURACIL 500 MG/10 ML VIAL	FLUOROURACIL	19.18%
68001026631	FLUOROURACIL 1,000 MG/20 ML VL	FLUOROURACIL	16.66%
68001026632	FLUOROURACIL 5 GM/100 ML VIAL	FLUOROURACIL	19.62%
00172496058	FLUTAMIDE 125 MG CAPSULE	FLUTAMIDE	41.33%
00172496070	FLUTAMIDE 125 MG CAPSULE	FLUTAMIDE	41.33%
00591246618	FLUTAMIDE 125 MG CAPSULE	FLUTAMIDE	41.33%
49884075313	FLUTAMIDE 125 MG CAPSULE	FLUTAMIDE	41.33%
58016017000	FLUTAMIDE 125 MG CAPSULE	FLUTAMIDE	41.33%
58016017030	FLUTAMIDE 125 MG CAPSULE	FLUTAMIDE	41.33%
58016017060	FLUTAMIDE 125 MG CAPSULE	FLUTAMIDE	41.33%
58016017090	FLUTAMIDE 125 MG CAPSULE	FLUTAMIDE	41.33%
58016017099	FLUTAMIDE 125 MG CAPSULE	FLUTAMIDE	41.33%

60429027218	FLUTAMIDE 125 MG CAPSULE	FLUTAMIDE	41.33%
55111067802	FONDAPARINUX 2.5 MG/0.5 ML SYR	FONDAPARINUX SODIUM	16.55%
55111067810	FONDAPARINUX 2.5 MG/0.5 ML SYR	FONDAPARINUX SODIUM	16.55%
55111067902	FONDAPARINUX 5 MG/0.4 ML SYR	FONDAPARINUX SODIUM	17.15%
55111067910	FONDAPARINUX 5 MG/0.4 ML SYR	FONDAPARINUX SODIUM	17.15%
55111068002	FONDAPARINUX 7.5 MG/0.6 ML SYR	FONDAPARINUX SODIUM	16.00%
55111068010	FONDAPARINUX 7.5 MG/0.6 ML SYR	FONDAPARINUX SODIUM	16.00%
55111068102	FONDAPARINUX 10 MG/0.8 ML SYR	FONDAPARINUX SODIUM	16.00%
55111068110	FONDAPARINUX 10 MG/0.8 ML SYR	FONDAPARINUX SODIUM	16.00%
60505607800	FONDAPARINUX 2.5 MG/0.5 ML SYR	FONDAPARINUX SODIUM	16.55%
60505607804	FONDAPARINUX 2.5 MG/0.5 ML SYR	FONDAPARINUX SODIUM	16.55%
60505607900	FONDAPARINUX 5 MG/0.4 ML SYR	FONDAPARINUX SODIUM	17.15%
60505607904	FONDAPARINUX 5 MG/0.4 ML SYR	FONDAPARINUX SODIUM	17.15%
60505608000	FONDAPARINUX 7.5 MG/0.6 ML SYR	FONDAPARINUX SODIUM	16.00%
60505608004	FONDAPARINUX 7.5 MG/0.6 ML SYR	FONDAPARINUX SODIUM	16.00%
60505608100	FONDAPARINUX 10 MG/0.8 ML SYR	FONDAPARINUX SODIUM	16.00%
60505608104	FONDAPARINUX 10 MG/0.8 ML SYR	FONDAPARINUX SODIUM	16.00%
67457058210	FONDAPARINUX 2.5 MG/0.5 ML SYR	FONDAPARINUX SODIUM	16.55%
67457058304	FONDAPARINUX 5 MG/0.4 ML SYR	FONDAPARINUX SODIUM	17.15%
67457058406	FONDAPARINUX 7.5 MG/0.6 ML SYR	FONDAPARINUX SODIUM	16.00%
67457058508	FONDAPARINUX 10 MG/0.8 ML SYR	FONDAPARINUX SODIUM	16.00%
67457069310	FONDAPARINUX 2.5 MG/0.5 ML SYR	FONDAPARINUX SODIUM	16.55%
67457069410	FONDAPARINUX 5 MG/0.4 ML SYR	FONDAPARINUX SODIUM	17.15%

67457069510	FONDAPARINUX 7.5 MG/0.6 ML SYR	FONDAPARINUX SODIUM	16.00%
67457069610	FONDAPARINUX 10 MG/0.8 ML SYR	FONDAPARINUX SODIUM	16.00%
63323031510	GANCICLOVIR 500 MG VIAL	GANCICLOVIR SODIUM	40.00%
63323031594	GANCICLOVIR 500 MG VIAL	GANCICLOVIR SODIUM	40.00%
00052030151	GANIRELIX ACET 250 MCG/0.5 ML	GANIRELIX ACETATE	13.01%
00069385710	GEMCITABINE HCL 200 MG VIAL	GEMCITABINE HCL	40.00%
00069385810	GEMCITABINE HCL 1 GRAM VIAL	GEMCITABINE HCL	40.00%
00069385910	GEMCITABINE HCL 2 GRAM VIAL	GEMCITABINE HCL	40.00%
00409018101	GEMCITABINE 1 GRAM/26.3 ML VL	GEMCITABINE HCL	40.00%
00409018125	GEMCITABINE 1 GRAM/26.3 ML VL	GEMCITABINE HCL	40.00%
00409018201	GEMCITABINE 2 GRAM/52.6 ML VL	GEMCITABINE HCL	40.00%
00409018225	GEMCITABINE 2 GRAM/52.6 ML VL	GEMCITABINE HCL	40.00%
00409018301	GEMCITABINE 200 MG/5.26 ML VL	GEMCITABINE HCL	40.00%
00409018325	GEMCITABINE 200 MG/5.26 ML VL	GEMCITABINE HCL	40.00%
00409018501	GEMCITABINE HCL 200 MG VIAL	GEMCITABINE HCL	40.00%
00409018601	GEMCITABINE HCL 1 GRAM VIAL	GEMCITABINE HCL	40.00%
00409018701	GEMCITABINE HCL 2 GRAM VIAL	GEMCITABINE HCL	40.00%
00591356279	GEMCITABINE HCL 200 MG VIAL	GEMCITABINE HCL	40.00%
00591356355	GEMCITABINE HCL 1 GRAM VIAL	GEMCITABINE HCL	40.00%
00703577501	GEMCITABINE HCL 200 MG VIAL	GEMCITABINE HCL	40.00%
00703577801	GEMCITABINE HCL 1 GRAM VIAL	GEMCITABINE HCL	40.00%
00781328275	GEMCITABINE HCL 200 MG VIAL	GEMCITABINE HCL	40.00%
00781328379	GEMCITABINE HCL 1 GRAM VIAL	GEMCITABINE HCL	40.00%

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16729009203	GEMCITABINE HCL 200 MG VIAL	GEMCITABINE HCL	40.00%
16729011711	GEMCITABINE HCL 1 GRAM VIAL	GEMCITABINE HCL	40.00%
16729011838	GEMCITABINE HCL 2 GRAM VIAL	GEMCITABINE HCL	40.00%
23155021331	GEMCITABINE HCL 200 MG VIAL	GEMCITABINE HCL	40.00%
23155021431	GEMCITABINE HCL 1 GRAM VIAL	GEMCITABINE HCL	40.00%
23155048431	GEMCITABINE HCL 1 GRAM VIAL	GEMCITABINE HCL	40.00%
25021020810	GEMCITABINE HCL 200 MG VIAL	GEMCITABINE HCL	40.00%
25021020950	GEMCITABINE HCL 1 GRAM VIAL	GEMCITABINE HCL	40.00%
25021023410	GEMCITABINE HCL 200 MG VIAL	GEMCITABINE HCL	40.00%
25021023550	GEMCITABINE HCL 1 GRAM VIAL	GEMCITABINE HCL	40.00%
45963061257	GEMCITABINE HCL 200 MG VIAL	GEMCITABINE HCL	40.00%
45963061959	GEMCITABINE HCL 1 GRAM VIAL	GEMCITABINE HCL	40.00%
45963062357	GEMCITABINE 200 MG/5.26 ML VL	GEMCITABINE HCL	40.00%
45963062458	GEMCITABINE 1 GRAM/26.3 ML VL	GEMCITABINE HCL	40.00%
45963063660	GEMCITABINE 2 GRAM/52.6 ML VL	GEMCITABINE HCL	40.00%
47335015340	GEMCITABINE HCL 200 MG VIAL	GEMCITABINE HCL	40.00%
47335015440	GEMCITABINE HCL 1 GRAM VIAL	GEMCITABINE HCL	40.00%
55111068607	GEMCITABINE HCL 200 MG VIAL	GEMCITABINE HCL	40.00%
55111068725	GEMCITABINE HCL 1 GRAM VIAL	GEMCITABINE HCL	40.00%
55390039110	GEMCITABINE HCL 200 MG VIAL	GEMCITABINE HCL	40.00%
55390039150	GEMCITABINE HCL 1 GRAM VIAL	GEMCITABINE HCL	40.00%
63323010210	GEMCITABINE HCL 200 MG VIAL	GEMCITABINE HCL	40.00%
63323010213	GEMCITABINE HCL 200 MG VIAL	GEMCITABINE HCL	40.00%

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63323010294	GEMCITABINE HCL 200 MG VIAL	GEMCITABINE HCL	40.00%
63323012550	GEMCITABINE HCL 1 GRAM VIAL	GEMCITABINE HCL	40.00%
63323012553	GEMCITABINE HCL 1 GRAM VIAL	GEMCITABINE HCL	40.00%
63323012594	GEMCITABINE HCL 1 GRAM VIAL	GEMCITABINE HCL	40.00%
63323012600	GEMCITABINE HCL 2 GRAM VIAL	GEMCITABINE HCL	40.00%
67457046201	GEMCITABINE HCL 1 GRAM VIAL	GEMCITABINE HCL	40.00%
67457046302	GEMCITABINE HCL 2 GRAM VIAL	GEMCITABINE HCL	40.00%
67457046420	GEMCITABINE HCL 200 MG VIAL	GEMCITABINE HCL	40.00%
68001028222	GEMCITABINE HCL 200 MG VIAL	GEMCITABINE HCL	40.00%
68001028223	GEMCITABINE HCL 1 GRAM VIAL	GEMCITABINE HCL	40.00%
68001028224	GEMCITABINE HCL 2 GRAM VIAL	GEMCITABINE HCL	40.00%
68001028225	GEMCITABINE HCL 200 MG VIAL	GEMCITABINE HCL	40.00%
68001028226	GEMCITABINE HCL 1 GRAM VIAL	GEMCITABINE HCL	40.00%
68001028227	GEMCITABINE HCL 2 GRAM VIAL	GEMCITABINE HCL	40.00%
00781323434	GLATOPA 20 MG/ML SYRINGE	GLATIRAMER ACETATE	20.00%
08065183004	PROVISC 10 MG/ML DISP SYRNG	HYALURONATE SODIUM	19.09%
08065183055	PROVISC 10 MG/ML DISP SYRNG	HYALURONATE SODIUM	19.09%
08065183085	PROVISC 10 MG/ML DISP SYRNG	HYALURONATE SODIUM	19.09%
08363776101	SUPARTZ 10 MG/ML SYRINGE	HYALURONATE SODIUM	17.00%
50653000601	GENVISC 850 25 MG/2.5 ML SYR	HYALURONATE SODIUM	17.00%
55566410001	EUFLEXXA 20 MG/2 ML SYRINGE	HYALURONATE SODIUM	17.00%
85836015153	GEL-ONE 30 MG/3 ML SYRINGE	HYALURONATE SODIUM	17.00%
87541030091	GEL-ONE 30 MG/3 ML SYRINGE	HYALURONATE SODIUM	9.38%

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89130444401	SUPARTZ FX 25 MG/2.5 ML SYR	HYALURONATE SODIUM	17.00%
89130555501	SUPARTZ 25 MG/2.5 ML SYRINGE	HYALURONATE SODIUM	17.00%
25021082761	IBANDRONATE 3 MG/3 ML SYRINGE	IBANDRONATE SODIUM	40.00%
55150019183	IBANDRONATE 3 MG/3 ML SYRINGE	IBANDRONATE SODIUM	40.00%
62756021840	IBANDRONATE 3 MG/3 ML VIAL	IBANDRONATE SODIUM	40.00%
67457052433	IBANDRONATE 3 MG/3 ML SYRINGE	IBANDRONATE SODIUM	40.00%
00703415411	IDARUBICIN HCL 5 MG/5 ML VIAL	IDARUBICIN HCL	40.00%
00703415511	IDARUBICIN HCL 10 MG/10 ML VL	IDARUBICIN HCL	40.00%
00703415611	IDARUBICIN HCL 20 MG/20 ML VL	IDARUBICIN HCL	40.00%
59762258601	IDARUBICIN PFS 10 MG/10 ML VL	IDARUBICIN HCL	40.00%
63323019405	IDARUBICIN HCL 5 MG/5 ML VIAL	IDARUBICIN HCL	40.00%
63323019410	IDARUBICIN HCL 10 MG/10 ML VL	IDARUBICIN HCL	40.00%
63323019420	IDARUBICIN HCL 20 MG/20 ML VL	IDARUBICIN HCL	40.00%
00069449522	IFOSFAMIDE 1 GM/20 ML VIAL	IFOSFAMIDE	40.00%
00069449622	IFOSFAMIDE 3 GM/ 60 ML VIAL	IFOSFAMIDE	40.00%
00703342711	IFOSFAMIDE 1 GM/20 ML VIAL	IFOSFAMIDE	40.00%
00703342911	IFOSFAMIDE 3 GM/ 60 ML VIAL	IFOSFAMIDE	40.00%
10019092501	IFOSFAMIDE 1 GM VIAL	IFOSFAMIDE	40.00%
10019092582	IFOSFAMIDE 1 GM VIAL	IFOSFAMIDE	40.00%
10019092602	IFOSFAMIDE 3 GM VIAL	IFOSFAMIDE	40.00%
10019092616	IFOSFAMIDE 3 GM VIAL	IFOSFAMIDE	40.00%
63323014210	IFOSFAMIDE 1 GM VIAL	IFOSFAMIDE	40.00%
63323014212	IFOSFAMIDE 1 GM VIAL	IFOSFAMIDE	40.00%

63323017420	IFOSFAMIDE 1 GM/20 ML VIAL	IFOSFAMIDE	40.00%
63323017460	IFOSFAMIDE 3 GM/ 60 ML VIAL	IFOSFAMIDE	40.00%
67457044360	IFOSFAMIDE 3 GM/ 60 ML VIAL	IFOSFAMIDE	40.00%
67457060920	IFOSFAMIDE 1 GM/20 ML VIAL	IFOSFAMIDE	40.00%
00703410048	IFOSFAMIDE-MESNA KIT	IFOSFAMIDE/MESNA	40.00%
00093762998	IMATINIB MESYLATE 100 MG TAB	IMATINIB MESYLATE	40.00%
00093763056	IMATINIB MESYLATE 400 MG TAB	IMATINIB MESYLATE	45.15%
47335047281	IMATINIB MESYLATE 100 MG TAB	IMATINIB MESYLATE	25.00%
47335047583	IMATINIB MESYLATE 400 MG TAB	IMATINIB MESYLATE	25.00%
60505290009	IMATINIB MESYLATE 100 MG TAB	IMATINIB MESYLATE	40.00%
60505290103	IMATINIB MESYLATE 400 MG TAB	IMATINIB MESYLATE	45.15%
60687020325	IMATINIB MESYLATE 400 MG TAB	IMATINIB MESYLATE	25.00%
60687020395	IMATINIB MESYLATE 400 MG TAB	IMATINIB MESYLATE	25.00%
44206043940	PRIVIGEN 10% VIAL	IMMUNE GLOBULIN,GAMMA (IGG)	40.00%
64208823404	GAMMAPLEX 5% VIAL	IMMUNE GLOBULIN,GAMMA (IGG)	40.00%
64208823405	GAMMAPLEX 5% VIAL	IMMUNE GLOBULIN,GAMMA (IGG)	40.00%
64208823406	GAMMAPLEX 5% VIAL	IMMUNE GLOBULIN,GAMMA (IGG)	40.00%
64208823407	GAMMAPLEX 5% VIAL	IMMUNE GLOBULIN,GAMMA (IGG)	40.00%
64208823408	GAMMAPLEX 5% VIAL	IMMUNE GLOBULIN,GAMMA (IGG)	40.00%
00078056961	EXTAVIA 0.3 MG VIAL	INTERFERON BETA-1B	11.45%
00143970101	IRINOTECAN HCL 100 MG/5 ML VL	IRINOTECAN HCL	21.00%
00143970201	IRINOTECAN HCL 40 MG/2 ML VIAL	IRINOTECAN HCL	21.00%
00703443211	IRINOTECAN HCL 40 MG/2 ML VIAL	IRINOTECAN HCL	21.00%

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00703443411	IRINOTECAN HCL 100 MG/5 ML VL	IRINOTECAN HCL	21.00%
18111000202	IRINOTECAN HCL 40 MG/2 ML VIAL	IRINOTECAN HCL	21.00%
18111000203	IRINOTECAN HCL 100 MG/5 ML VL	IRINOTECAN HCL	21.00%
23155017931	IRINOTECAN HCL 40 MG/2 ML VIAL	IRINOTECAN HCL	21.00%
23155017932	IRINOTECAN HCL 100 MG/5 ML VL	IRINOTECAN HCL	21.00%
25021021402	IRINOTECAN HCL 40 MG/2 ML VIAL	IRINOTECAN HCL	21.00%
25021021405	IRINOTECAN HCL 100 MG/5 ML VL	IRINOTECAN HCL	21.00%
25021023002	IRINOTECAN HCL 40 MG/2 ML VIAL	IRINOTECAN HCL	21.00%
25021023005	IRINOTECAN HCL 100 MG/5 ML VL	IRINOTECAN HCL	21.00%
45963061451	IRINOTECAN HCL 40 MG/2 ML VIAL	IRINOTECAN HCL	21.00%
45963061455	IRINOTECAN HCL 100 MG/5 ML VL	IRINOTECAN HCL	21.00%
59762752901	IRINOTECAN HCL 40 MG/2 ML VIAL	IRINOTECAN HCL	21.00%
59762752902	IRINOTECAN HCL 100 MG/5 ML VL	IRINOTECAN HCL	21.00%
59923070202	IRINOTECAN HCL 40 MG/2 ML VIAL	IRINOTECAN HCL	21.00%
59923070205	IRINOTECAN HCL 100 MG/5 ML VL	IRINOTECAN HCL	21.00%
61703034909	IRINOTECAN HCL 100 MG/5 ML VL	IRINOTECAN HCL	21.00%
61703034916	IRINOTECAN HCL 40 MG/2 ML VIAL	IRINOTECAN HCL	21.00%
61703034936	IRINOTECAN HCL 500 MG/25 ML VL	IRINOTECAN HCL	16.66%
63323019302	IRINOTECAN HCL 40 MG/2 ML VIAL	IRINOTECAN HCL	21.00%
63323019305	IRINOTECAN HCL 100 MG/5 ML VL	IRINOTECAN HCL	21.00%
63323019352	IRINOTECAN HCL 40 MG/2 ML VIAL	IRINOTECAN HCL	21.00%
63323019355	IRINOTECAN HCL 100 MG/5 ML VL	IRINOTECAN HCL	21.00%
66758004801	IRINOTECAN HCL 40 MG/2 ML VIAL	IRINOTECAN HCL	21.00%

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66758004802	IRINOTECAN HCL 100 MG/5 ML VL	IRINOTECAN HCL	21.00%
68001028422	IRINOTECAN HCL 100 MG/5 ML VL	IRINOTECAN HCL	21.00%
68001028425	IRINOTECAN HCL 100 MG/5 ML VL	IRINOTECAN HCL	21.00%
68001028434	IRINOTECAN HCL 40 MG/2 ML VIAL	IRINOTECAN HCL	21.00%
68001028435	IRINOTECAN HCL 40 MG/2 ML VIAL	IRINOTECAN HCL	21.00%
00378516893	LAMIVUDINE 100 MG TABLET	LAMIVUDINE	16.00%
00378516991	LAMIVUDINE 150 MG TABLET	LAMIVUDINE	16.00%
00378517093	LAMIVUDINE 300 MG TABLET	LAMIVUDINE	16.00%
10135060571	LAMIVUDINE 10 MG/ML ORAL SOLN	LAMIVUDINE	16.00%
31722075260	LAMIVUDINE HBV 100 MG TABLET	LAMIVUDINE	16.00%
31722075360	LAMIVUDINE 150 MG TABLET	LAMIVUDINE	16.00%
31722075430	LAMIVUDINE 300 MG TABLET	LAMIVUDINE	16.00%
54838056670	LAMIVUDINE 10 MG/ML ORAL SOLN	LAMIVUDINE	16.00%
60429035360	LAMIVUDINE 150 MG TABLET	LAMIVUDINE	16.00%
60429035430	LAMIVUDINE 300 MG TABLET	LAMIVUDINE	16.00%
60505325106	LAMIVUDINE 150 MG TABLET	LAMIVUDINE	16.00%
60505325203	LAMIVUDINE 300 MG TABLET	LAMIVUDINE	16.00%
65862055260	LAMIVUDINE 150 MG TABLET	LAMIVUDINE	16.00%
65862055330	LAMIVUDINE 300 MG TABLET	LAMIVUDINE	16.00%
68084057811	LAMIVUDINE 150 MG TABLET	LAMIVUDINE	16.00%
68084057821	LAMIVUDINE 150 MG TABLET	LAMIVUDINE	16.00%
68180060207	LAMIVUDINE 150 MG TABLET	LAMIVUDINE	16.00%
68180060306	LAMIVUDINE 300 MG TABLET	LAMIVUDINE	16.00%

00093538506	LAMIVUDINE-ZIDOVUDINE TABLET	LAMIVUDINE/ZIDOVUDINE	26.64%
00378518091	LAMIVUDINE-ZIDOVUDINE TABLET	LAMIVUDINE/ZIDOVUDINE	26.64%
21695099602	LAMIVUDINE-ZIDOVUDINE TABLET	LAMIVUDINE/ZIDOVUDINE	26.64%
21695099660	LAMIVUDINE-ZIDOVUDINE TABLET	LAMIVUDINE/ZIDOVUDINE	26.64%
31722050660	LAMIVUDINE-ZIDOVUDINE TABLET	LAMIVUDINE/ZIDOVUDINE	26.64%
31722073960	LAMIVUDINE-ZIDOVUDINE TABLET	LAMIVUDINE/ZIDOVUDINE	26.64%
42254038102	LAMIVUDINE-ZIDOVUDINE TABLET	LAMIVUDINE/ZIDOVUDINE	26.64%
42254038106	LAMIVUDINE-ZIDOVUDINE TABLET	LAMIVUDINE/ZIDOVUDINE	26.64%
42291036360	LAMIVUDINE-ZIDOVUDINE TABLET	LAMIVUDINE/ZIDOVUDINE	26.64%
43063034606	LAMIVUDINE-ZIDOVUDINE TABLET	LAMIVUDINE/ZIDOVUDINE	26.64%
54569648400	LAMIVUDINE-ZIDOVUDINE TABLET	LAMIVUDINE/ZIDOVUDINE	26.64%
54569648401	LAMIVUDINE-ZIDOVUDINE TABLET	LAMIVUDINE/ZIDOVUDINE	26.64%
55700009604	LAMIVUDINE-ZIDOVUDINE TABLET	LAMIVUDINE/ZIDOVUDINE	26.64%
60760038514	LAMIVUDINE-ZIDOVUDINE TABLET	LAMIVUDINE/ZIDOVUDINE	26.64%
64380070703	LAMIVUDINE-ZIDOVUDINE TABLET	LAMIVUDINE/ZIDOVUDINE	26.64%
65862059760	LAMIVUDINE-ZIDOVUDINE TABLET	LAMIVUDINE/ZIDOVUDINE	26.64%
68071090806	LAMIVUDINE-ZIDOVUDINE TABLET	LAMIVUDINE/ZIDOVUDINE	26.64%
68084041621	LAMIVUDINE-ZIDOVUDINE TABLET	LAMIVUDINE/ZIDOVUDINE	26.64%
68180028407	LAMIVUDINE-ZIDOVUDINE TABLET	LAMIVUDINE/ZIDOVUDINE	26.64%
76282011560	LAMIVUDINE-ZIDOVUDINE TABLET	LAMIVUDINE/ZIDOVUDINE	26.64%
00054449613	LEUCOVORIN CALCIUM 5 MG TAB	LEUCOVORIN CALCIUM	15.00%
00054449625	LEUCOVORIN CALCIUM 5 MG TAB	LEUCOVORIN CALCIUM	15.00%
00054449705	LEUCOVORIN CALCIUM 10 MG TAB	LEUCOVORIN CALCIUM	16.00%

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00054449710	LEUCOVORIN CALCIUM 10 MG TAB	LEUCOVORIN CALCIUM	16.00%
00054449810	LEUCOVORIN CALCIUM 15 MG TAB	LEUCOVORIN CALCIUM	28.51%
00054449911	LEUCOVORIN CALCIUM 25 MG TAB	LEUCOVORIN CALCIUM	60.72%
00054849619	LEUCOVORIN CALCIUM 5 MG TAB	LEUCOVORIN CALCIUM	15.00%
00143955201	LEUCOVORIN CALCIUM 350 MG VIAL	LEUCOVORIN CALCIUM	16.66%
00555048401	LEUCOVORIN CALCIUM 5 MG TAB	LEUCOVORIN CALCIUM	15.00%
00555048402	LEUCOVORIN CALCIUM 5 MG TAB	LEUCOVORIN CALCIUM	15.00%
00555048527	LEUCOVORIN CALCIUM 25 MG TAB	LEUCOVORIN CALCIUM	60.72%
00703514001	LEUCOVORIN CALCIUM 100 MG VIAL	LEUCOVORIN CALCIUM	16.66%
00703514501	LEUCOVORIN CALCIUM 350 MG VIAL	LEUCOVORIN CALCIUM	16.66%
00703514591	LEUCOVORIN CALCIUM 350 MG VIAL	LEUCOVORIN CALCIUM	16.66%
25021081310	LEUCOVORIN CALCIUM 50 MG VIAL	LEUCOVORIN CALCIUM	16.66%
25021081366	LEUCOVORIN CALCIUM 50 MG VIAL	LEUCOVORIN CALCIUM	16.66%
25021081430	LEUCOVORIN CALCIUM 100 MG VIAL	LEUCOVORIN CALCIUM	16.66%
25021081467	LEUCOVORIN CALCIUM 100 MG VIAL	LEUCOVORIN CALCIUM	16.66%
25021081530	LEUCOVORIN CALCIUM 200 MG VIAL	LEUCOVORIN CALCIUM	14.69%
25021081567	LEUCOVORIN CALCIUM 200 MG VIAL	LEUCOVORIN CALCIUM	14.69%
25021081630	LEUCOVORIN CALCIUM 350 MG VIAL	LEUCOVORIN CALCIUM	16.66%

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25021081667	LEUCOVORIN CALCIUM 350 MG VIAL	LEUCOVORIN CALCIUM	16.66%
51079058101	LEUCOVORIN CALCIUM 5 MG TAB	LEUCOVORIN CALCIUM	15.00%
51079058106	LEUCOVORIN CALCIUM 5 MG TAB	LEUCOVORIN CALCIUM	15.00%
51079058201	LEUCOVORIN CALCIUM 25 MG TAB	LEUCOVORIN CALCIUM	60.72%
51079058205	LEUCOVORIN CALCIUM 25 MG TAB	LEUCOVORIN CALCIUM	60.72%
54868331000	LEUCOVORIN CALCIUM 5 MG TAB	LEUCOVORIN CALCIUM	15.00%
54868331001	LEUCOVORIN CALCIUM 5 MG TAB	LEUCOVORIN CALCIUM	15.00%
54868331003	LEUCOVORIN CALCIUM 5 MG TAB	LEUCOVORIN CALCIUM	15.00%
54868331004	LEUCOVORIN CALCIUM 5 MG TAB	LEUCOVORIN CALCIUM	15.00%
54868591500	LEUCOVORIN CALCIUM 15 MG TAB	LEUCOVORIN CALCIUM	28.51%
55390000901	LEUCOVORIN CAL 500 MG/50 ML VL	LEUCOVORIN CALCIUM	16.66%
55390005110	LEUCOVORIN CALCIUM 50 MG VIAL	LEUCOVORIN CALCIUM	16.66%
55390005210	LEUCOVORIN CALCIUM 100 MG VIAL	LEUCOVORIN CALCIUM	16.66%
55390005301	LEUCOVORIN CALCIUM 200 MG VIAL	LEUCOVORIN CALCIUM	14.69%
55390005401	LEUCOVORIN CALCIUM 350 MG VIAL	LEUCOVORIN CALCIUM	16.66%
55390081810	LEUCOVORIN CALCIUM 100 MG VIAL	LEUCOVORIN CALCIUM	16.66%
55390082401	LEUCOVORIN CALCIUM 200 MG VIAL	LEUCOVORIN CALCIUM	14.69%
55390082501	LEUCOVORIN CALCIUM 350 MG VIAL	LEUCOVORIN CALCIUM	16.66%
55390082601	LEUCOVORIN CAL 500 MG/50 ML VL	LEUCOVORIN CALCIUM	16.66%

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63323071050	LEUCOVORIN CALCIUM 200 MG VIAL	LEUCOVORIN CALCIUM	14.69%
63323071059	LEUCOVORIN CALCIUM 200 MG VIAL	LEUCOVORIN CALCIUM	14.69%
63323071100	LEUCOVORIN CALCIUM 500 MG VL	LEUCOVORIN CALCIUM	16.66%
00703401418	LEUPROLIDE 2WK 1 MG/0.2 ML KIT	LEUPROLIDE ACETATE	40.02%
00781400332	LEUPROLIDE 2WK 1 MG/0.2 ML KIT	LEUPROLIDE ACETATE	40.02%
41616093640	LEUPROLIDE 2WK 1 MG/0.2 ML KIT	LEUPROLIDE ACETATE	40.02%
47335093640	LEUPROLIDE 2WK 1 MG/0.2 ML KIT	LEUPROLIDE ACETATE	40.00%
67457019501	MELPHALAN HCL 50 MG VIAL	MELPHALAN HCL	40.00%
67457021501	MELPHALAN HCL 50 MG VIAL	MELPHALAN HCL	40.00%
67457057901	MELPHALAN HCL 50 MG VIAL	MELPHALAN HCL	40.00%
00703480503	MESNA 1 GRAM/10 ML VIAL	MESNA	40.00%
10019095301	MESNA 1 GRAM/10 ML VIAL	MESNA	40.00%
10019095302	MESNA 1 GRAM/10 ML VIAL	MESNA	40.00%
10019095362	MESNA 1 GRAM/10 ML VIAL	MESNA	40.00%
25021020110	MESNA 100 MG/ML VIAL	MESNA	40.00%
25021020111	MESNA 100 MG/ML VIAL	MESNA	40.00%
25021020166	MESNA 1 GRAM/10 ML VIAL	MESNA	40.00%
25021020167	MESNA 1 GRAM/10 ML VIAL	MESNA	40.00%
25021020168	MESNA 1 GRAM/10 ML VIAL	MESNA	40.00%
25021020169	MESNA 1 GRAM/10 ML VIAL	MESNA	40.00%
55390004501	MESNA 100 MG/ML VIAL	MESNA	40.00%
55390026601	MESNA 100 MG/ML VIAL	MESNA	40.00%

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55390034701	MESNA 100 MG/ML VIAL	MESNA	40.00%
63323073310	MESNA 100 MG/ML VIAL	MESNA	40.00%
63323073311	MESNA 100 MG/ML VIAL	MESNA	40.00%
67457014800	MESNA 1 GRAM/10 ML VIAL	MESNA	40.00%
67457014810	MESNA 1 GRAM/10 ML VIAL	MESNA	40.00%
00054455015	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
00054455025	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
00054855025	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
00378001401	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
00378001450	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
00555057202	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
00555057235	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
00904601260	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
21695011100	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
21695011130	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
23490588900	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
42254011030	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
49999038024	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
49999038036	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
51079067001	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
51079067005	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
52959024400	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
54569181809	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%

54868382601	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	88.50%
54868382603	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
54868382604	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
54868382605	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
54868382606	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
54868382607	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
54868382608	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
54868382609	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
55289092430	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
61703035010	METHOTREXATE 50 MG/2 ML VIAL	METHOTREXATE SODIUM	15.00%
61703035038	METHOTREXATE 50 MG/2 ML VIAL	METHOTREXATE SODIUM	15.00%
63323012310	METHOTREXATE 250 MG/10 ML VIAL	METHOTREXATE SODIUM	15.00%
63629147201	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
63629147202	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
67253032010	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
67253032036	METHOTREXATE 2.5 MG TABLET	METHOTREXATE SODIUM	50.06%
00069014601	METHOTREXATE 50 MG/2 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
00069014602	METHOTREXATE 50 MG/2 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
00069014701	METHOTREXATE 100 MG/4 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
00069014702	METHOTREXATE 100 MG/4 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
00069014801	METHOTREXATE 250 MG/10 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
00069014901	METHOTREXATE 1 GM/40 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
00069018101	METHOTREXATE 200 MG/8 ML VIAL	METHOTREXATE SODIUM/PF	29.84%

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00069018102	METHOTREXATE 200 MG/8 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
00069020410	METHOTREXATE 200 MG/8 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
00703367101	METHOTREXATE 50 MG/2 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
00703367103	METHOTREXATE 50 MG/2 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
00703367193	METHOTREXATE 50 MG/2 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
00703367301	METHOTREXATE 100 MG/4 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
00703367501	METHOTREXATE 250 MG/10 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
00703367591	METHOTREXATE 250 MG/10 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
00703367801	METHOTREXATE 1 GRAM/40 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
10139006202	METHOTREXATE 50 MG/2 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
10139006210	METHOTREXATE 250 MG/10 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
10139006240	METHOTREXATE 1 GM/40 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
16729027703	METHOTREXATE 250 MG/10 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
16729027730	METHOTREXATE 50 MG/2 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
16729027735	METHOTREXATE 1 GRAM/40 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
55390003110	METHOTREXATE 50 MG/2 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
55390003210	METHOTREXATE 100 MG/4 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
55390003310	METHOTREXATE 200 MG/8 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
55390003410	METHOTREXATE 250 MG/10 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
55390014301	METHOTREXATE 1 GM VIAL	METHOTREXATE SODIUM/PF	16.66%
61703040825	METHOTREXATE 1 GRAM/40 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
61703040841	METHOTREXATE 1 GRAM/40 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
63323012102	METHOTREXATE 25 MG/ML VIAL	METHOTREXATE SODIUM/PF	29.84%

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63323012108	METHOTREXATE 25 MG/ML VIAL	METHOTREXATE SODIUM/PF	29.84%
63323012110	METHOTREXATE 25 MG/ML VIAL	METHOTREXATE SODIUM/PF	29.84%
63323012250	METHOTREXATE 1 GM VIAL	METHOTREXATE SODIUM/PF	16.66%
63323012259	METHOTREXATE 1 GM VIAL	METHOTREXATE SODIUM/PF	16.66%
66758004101	METHOTREXATE 1 GRAM/40 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
67457022102	METHOTREXATE 50 MG/2 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
67457022110	METHOTREXATE 250 MG/10 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
67457022140	METHOTREXATE 1 GRAM/40 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
67457046610	METHOTREXATE 250 MG/10 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
67457048040	METHOTREXATE 1 GRAM/40 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
67457048599	METHOTREXATE 200 MG/8 ML VIAL	METHOTREXATE SODIUM/PF	29.84%
16729010811	MITOMYCIN 20 MG VIAL	MITOMYCIN	11.45%
16729011505	MITOMYCIN 5 MG VIAL	MITOMYCIN	11.45%
16729011638	MITOMYCIN 40 MG VIAL	MITOMYCIN	11.45%
16729024605	MITOMYCIN 5 MG VIAL	MITOMYCIN	11.45%
16729024711	MITOMYCIN 20 MG VIAL	MITOMYCIN	11.45%
16729024838	MITOMYCIN 40 MG VIAL	MITOMYCIN	11.45%
55390025101	MITOMYCIN 5 MG VIAL	MITOMYCIN	11.45%
55390025201	MITOMYCIN 20 MG VIAL	MITOMYCIN	11.45%
55390025301	MITOMYCIN 40 MG VIAL	MITOMYCIN	11.45%
55390045101	MITOMYCIN 5 MG VIAL	MITOMYCIN	11.45%
55390045201	MITOMYCIN 20 MG VIAL	MITOMYCIN	11.45%
55390045301	MITOMYCIN 40 MG VIAL	MITOMYCIN	11.45%

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00703468001	MITOXANTRONE 25 MG/12.5 ML VL	MITOXANTRONE HCL	40.00%
00703468501	MITOXANTRONE 20 MG/10 ML VIAL	MITOXANTRONE HCL	40.00%
00703468601	MITOXANTRONE 30 MG/15 ML VIAL	MITOXANTRONE HCL	40.00%
61703034318	MITOXANTRONE 20 MG/10 ML VIAL	MITOXANTRONE HCL	40.00%
61703034365	MITOXANTRONE 25 MG/12.5 ML VL	MITOXANTRONE HCL	40.00%
61703034366	MITOXANTRONE 30 MG/15 ML VIAL	MITOXANTRONE HCL	40.00%
63323013210	MITOXANTRONE 20 MG/10 ML VIAL	MITOXANTRONE HCL	40.00%
63323013212	MITOXANTRONE 25 MG/12.5 ML VL	MITOXANTRONE HCL	40.00%
63323013215	MITOXANTRONE 30 MG/15 ML VIAL	MITOXANTRONE HCL	40.00%
00054016325	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
00054016329	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
00054016625	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
00054016629	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
00093733401	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
00093733405	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
00093733419	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
00093733493	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
00093747701	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
00093747705	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
00378225001	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
00378225005	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
00378447201	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
00378447205	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%

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00781206701	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
00781206705	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
00781206789	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
00781517501	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
00781517505	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
16729001901	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
16729001916	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
16729009401	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
16729009416	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
51079037901	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
51079037920	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
51079072101	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
51079072120	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
59762070201	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
59762070203	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
59762070301	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
59762070302	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
59762070303	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
60505296701	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
60505296705	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
60505296707	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
60505296801	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
60505296805	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%

60505296807	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
64380072506	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
64380072507	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
64380072606	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
64380072607	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
67877022501	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
67877022505	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
67877023022	MYCOPHENOLATE 200 MG/ML SUSP	MYCOPHENOLATE MOFETIL	54.00%
67877026601	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
67877026605	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
68084017701	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
68084017711	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
68084017801	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
68084017811	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
68084058701	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
68084058711	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
68084058801	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
68084058811	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
68084079501	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.86%
68084079511	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
68084080101	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
68084080111	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
68382013001	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%

68382013005	MYCOPHENOLATE 250 MG CAPSULE	MYCOPHENOLATE MOFETIL	86.85%
68382013101	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
68382013105	MYCOPHENOLATE 500 MG TABLET	MYCOPHENOLATE MOFETIL	88.70%
00378420178	MYCOPHENOLIC ACID DR 180 MG TB	MYCOPHENOLATE SODIUM	16.00%
00378420278	MYCOPHENOLIC ACID DR 360 MG TB	MYCOPHENOLATE SODIUM	16.00%
51079050820	MYCOPHENOLIC ACID DR 180 MG TB	MYCOPHENOLATE SODIUM	16.00%
51079050920	MYCOPHENOLIC ACID DR 360 MG TB	MYCOPHENOLATE SODIUM	16.00%
60505296507	MYCOPHENOLIC ACID DR 180 MG TB	MYCOPHENOLATE SODIUM	16.00%
60505296607	MYCOPHENOLIC ACID DR 360 MG TB	MYCOPHENOLATE SODIUM	16.00%
68084090721	MYCOPHENOLIC ACID DR 180 MG TB	MYCOPHENOLATE SODIUM	16.00%
68084091825	MYCOPHENOLIC ACID DR 360 MG TB	MYCOPHENOLATE SODIUM	16.00%
00054045058	NEVIRAPINE 50 MG/5 ML SUSP	NEVIRAPINE	16.00%
00054045921	NEVIRAPINE 200 MG TABLET	NEVIRAPINE	92.31%
00378405091	NEVIRAPINE 200 MG TABLET	NEVIRAPINE	92.31%
00378489093	NEVIRAPINE ER 400 MG TABLET	NEVIRAPINE	16.00%
00378695077	NEVIRAPINE ER 100 MG TABLET	NEVIRAPINE	16.00%
00781589331	NEVIRAPINE ER 400 MG TABLET	NEVIRAPINE	16.00%
13925050060	NEVIRAPINE 200 MG TABLET	NEVIRAPINE	92.31%
31722050560	NEVIRAPINE 200 MG TABLET	NEVIRAPINE	92.31%
47781010060	NEVIRAPINE 200 MG TABLET	NEVIRAPINE	92.31%
51991033106	NEVIRAPINE 200 MG TABLET	NEVIRAPINE	92.31%
60429029860	NEVIRAPINE 200 MG TABLET	NEVIRAPINE	92.31%
60505378806	NEVIRAPINE 200 MG TABLET	NEVIRAPINE	92.31%

60505405803	NEVIRAPINE ER 400 MG TABLET	NEVIRAPINE	16.00%
61442047060	NEVIRAPINE 200 MG TABLET	NEVIRAPINE	92.31%
65162020906	NEVIRAPINE 200 MG TABLET	NEVIRAPINE	92.31%
65862002760	NEVIRAPINE 200 MG TABLET	NEVIRAPINE	92.31%
69097040302	NEVIRAPINE ER 400 MG TABLET	NEVIRAPINE	16.00%
00703330104	OCTREOTIDE ACET 0.05 MG/ML VL	OCTREOTIDE ACETATE	15.00%
00703331104	OCTREOTIDE ACET 100 MCG/ML VL	OCTREOTIDE ACETATE	15.00%
00703332104	OCTREOTIDE ACET 500 MCG/ML VL	OCTREOTIDE ACETATE	15.00%
00703333301	OCTREOTIDE ACET 200 MCG/ML VL	OCTREOTIDE ACETATE	47.51%
00703334301	OCTREOTIDE 1,000 MCG/ML VIAL	OCTREOTIDE ACETATE	37.97%
00781316475	OCTREOTIDE 1,000 MCG/ML VIAL	OCTREOTIDE ACETATE	37.97%
00781316575	OCTREOTIDE ACET 200 MCG/ML VL	OCTREOTIDE ACETATE	47.51%
00781916475	OCTREOTIDE 1,000 MCG/ML VIAL	OCTREOTIDE ACETATE	37.97%
00781916575	OCTREOTIDE ACET 200 MCG/ML VL	OCTREOTIDE ACETATE	47.51%
00781916671	OCTREOTIDE ACET 50 MCG/ML AMP	OCTREOTIDE ACETATE	16.00%
00781916695	OCTREOTIDE ACET 50 MCG/ML AMP	OCTREOTIDE ACETATE	16.00%
00781916771	OCTREOTIDE ACET 100 MCG/ML AMP	OCTREOTIDE ACETATE	26.20%
00781916795	OCTREOTIDE ACET 100 MCG/ML AMP	OCTREOTIDE ACETATE	26.20%
00781916871	OCTREOTIDE ACET 500 MCG/ML AMP	OCTREOTIDE ACETATE	16.00%
00781916895	OCTREOTIDE ACET 500 MCG/ML AMP	OCTREOTIDE ACETATE	16.00%
25021045101	OCTREOTIDE ACET 50 MCG/ML VIAL	OCTREOTIDE ACETATE	15.00%
25021045201	OCTREOTIDE ACET 100 MCG/ML VL	OCTREOTIDE ACETATE	15.00%
25021045301	OCTREOTIDE ACET 500 MCG/ML VL	OCTREOTIDE ACETATE	15.00%

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25021045405	OCTREOTIDE 1,000 MCG/5 ML VIAL	OCTREOTIDE ACETATE	47.51%
25021045505	OCTREOTIDE 5,000 MCG/5 ML VIAL	OCTREOTIDE ACETATE	37.97%
55390016010	OCTREOTIDE ACET 50 MCG/ML VIAL	OCTREOTIDE ACETATE	15.00%
55390016110	OCTREOTIDE ACET 100 MCG/ML VL	OCTREOTIDE ACETATE	15.00%
55390016210	OCTREOTIDE ACET 500 MCG/ML VL	OCTREOTIDE ACETATE	15.00%
55390016301	OCTREOTIDE ACET 200 MCG/ML VL	OCTREOTIDE ACETATE	47.51%
55390016401	OCTREOTIDE 1,000 MCG/ML VIAL	OCTREOTIDE ACETATE	37.97%
55390037510	OCTREOTIDE ACET 100 MCG/ML VL	OCTREOTIDE ACETATE	15.00%
55390037610	OCTREOTIDE ACET 500 MCG/ML VL	OCTREOTIDE ACETATE	15.00%
55390037701	OCTREOTIDE ACET 200 MCG/ML VL	OCTREOTIDE ACETATE	47.51%
62756009444	OCTREOTIDE ACET 100 MCG/ML VL	OCTREOTIDE ACETATE	15.00%
62756034844	OCTREOTIDE ACET 50 MCG/ML AMP	OCTREOTIDE ACETATE	16.00%
62756034944	OCTREOTIDE ACET 100 MCG/ML AMP	OCTREOTIDE ACETATE	26.20%
62756035040	OCTREOTIDE ACET 200 MCG/ML VL	OCTREOTIDE ACETATE	47.51%
62756035144	OCTREOTIDE ACET 500 MCG/ML AMP	OCTREOTIDE ACETATE	16.00%
62756035240	OCTREOTIDE 1,000 MCG/ML VIAL	OCTREOTIDE ACETATE	37.97%
63323036501	OCTREOTIDE ACET 50 MCG/ML VIAL	OCTREOTIDE ACETATE	15.00%
63323036504	OCTREOTIDE ACET 50 MCG/ML VIAL	OCTREOTIDE ACETATE	15.00%
63323037601	OCTREOTIDE ACET 100 MCG/ML VL	OCTREOTIDE ACETATE	15.00%
63323037604	OCTREOTIDE ACET 100 MCG/ML VL	OCTREOTIDE ACETATE	15.00%
63323037701	OCTREOTIDE ACET 500 MCG/ML VL	OCTREOTIDE ACETATE	15.00%
63323037704	OCTREOTIDE ACET 500 MCG/ML VL	OCTREOTIDE ACETATE	15.00%
63323037805	OCTREOTIDE ACET 200 MCG/ML VL	OCTREOTIDE ACETATE	47.51%

63323037905	OCTREOTIDE 1,000 MCG/ML VIAL	OCTREOTIDE ACETATE	37.97%
64679063201	OCTREOTIDE 1,000 MCG/ML VIAL	OCTREOTIDE ACETATE	37.97%
64679063302	OCTREOTIDE ACET 100 MCG/ML VL	OCTREOTIDE ACETATE	15.00%
64679063401	OCTREOTIDE ACET 200 MCG/ML VL	OCTREOTIDE ACETATE	47.51%
64679063502	OCTREOTIDE ACET 500 MCG/ML VL	OCTREOTIDE ACETATE	15.00%
67457023900	OCTREOTIDE ACET 50 MCG/ML SYR	OCTREOTIDE ACETATE	15.00%
67457023901	OCTREOTIDE ACET 50 MCG/ML SYR	OCTREOTIDE ACETATE	15.00%
67457024500	OCTREOTIDE ACET 100 MCG/ML SYR	OCTREOTIDE ACETATE	15.00%
67457024501	OCTREOTIDE ACET 100 MCG/ML SYR	OCTREOTIDE ACETATE	15.00%
67457024600	OCTREOTIDE ACET 500 MCG/ML SYR	OCTREOTIDE ACETATE	15.00%
67457024601	OCTREOTIDE ACET 500 MCG/ML SYR	OCTREOTIDE ACETATE	15.00%
00069006701	OXALIPLATIN 50 MG VIAL	OXALIPLATIN	16.66%
00069007001	OXALIPLATIN 100 MG/20 ML VIAL	OXALIPLATIN	47.19%
00069007401	OXALIPLATIN 50 MG/10 ML VIAL	OXALIPLATIN	46.85%
00069101001	OXALIPLATIN 100 MG VIAL	OXALIPLATIN	16.66%
00781331570	OXALIPLATIN 50 MG/10 ML VIAL	OXALIPLATIN	46.85%
00781331780	OXALIPLATIN 100 MG/20 ML VIAL	OXALIPLATIN	47.19%
00781931570	OXALIPLATIN 50 MG/10 ML VIAL	OXALIPLATIN	46.85%
00781931780	OXALIPLATIN 100 MG/20 ML VIAL	OXALIPLATIN	47.19%
00955172510	OXALIPLATIN 50 MG/10 ML VIAL	OXALIPLATIN	46.85%
00955172720	OXALIPLATIN 100 MG/20 ML VIAL	OXALIPLATIN	47.19%
00955173110	OXALIPLATIN 50 MG/10 ML VIAL	OXALIPLATIN	46.85%
00955173320	OXALIPLATIN 100 MG/20 ML VIAL	OXALIPLATIN	47.19%

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25021021120	OXALIPLATIN 50 MG VIAL	OXALIPLATIN	16.66%
25021021250	OXALIPLATIN 100 MG VIAL	OXALIPLATIN	16.66%
25021023310	OXALIPLATIN 50 MG/10 ML VIAL	OXALIPLATIN	46.85%
25021023320	OXALIPLATIN 100 MG/20 ML VIAL	OXALIPLATIN	47.19%
41616017640	OXALIPLATIN 50 MG VIAL	OXALIPLATIN	16.66%
41616017840	OXALIPLATIN 100 MG VIAL	OXALIPLATIN	16.66%
45963061153	OXALIPLATIN 50 MG VIAL	OXALIPLATIN	16.66%
45963061159	OXALIPLATIN 100 MG VIAL	OXALIPLATIN	16.66%
47335004640	OXALIPLATIN 50 MG/10 ML VIAL	OXALIPLATIN	46.85%
47335004740	OXALIPLATIN 100 MG/20 ML VIAL	OXALIPLATIN	47.19%
47335017640	OXALIPLATIN 50 MG VIAL	OXALIPLATIN	16.66%
47335017840	OXALIPLATIN 100 MG VIAL	OXALIPLATIN	16.66%
61703036318	OXALIPLATIN 50 MG/10 ML VIAL	OXALIPLATIN	46.85%
61703036322	OXALIPLATIN 100 MG/20 ML VIAL	OXALIPLATIN	47.19%
63323021110	OXALIPLATIN 50 MG/10 ML VIAL	OXALIPLATIN	46.85%
63323021220	OXALIPLATIN 100 MG/20 ML VIAL	OXALIPLATIN	47.19%
63323065010	OXALIPLATIN 50 MG/10 ML VIAL	OXALIPLATIN	46.85%
63323065017	OXALIPLATIN 50 MG/10 ML VIAL	OXALIPLATIN	46.85%
63323065020	OXALIPLATIN 100 MG/20 ML VIAL	OXALIPLATIN	47.19%
63323065027	OXALIPLATIN 100 MG/20 ML VIAL	OXALIPLATIN	47.19%
63323075010	OXALIPLATIN 50 MG/10 ML VIAL	OXALIPLATIN	46.85%
67457044220	OXALIPLATIN 100 MG/20 ML VIAL	OXALIPLATIN	47.19%
67457047610	OXALIPLATIN 100 MG VIAL	OXALIPLATIN	16.66%

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00069007601	PACLITAXEL 100 MG/16.7 ML VIAL	PACLITAXEL	11.00%
00069007801	PACLITAXEL 300 MG/50 ML VIAL	PACLITAXEL	11.00%
00069007901	PACLITAXEL 30 MG/5 ML VIAL	PACLITAXEL	11.00%
00703476401	PACLITAXEL 30 MG/5 ML VIAL	PACLITAXEL	11.00%
00703476481	PACLITAXEL 30 MG/5 ML VIAL	PACLITAXEL	11.00%
00703476601	PACLITAXEL 100 MG/16.7 ML VIAL	PACLITAXEL	11.00%
00703476681	PACLITAXEL 100 MG/16.7 ML VIAL	PACLITAXEL	11.00%
00703476701	PACLITAXEL 150 MG/25 ML VIAL	PACLITAXEL	11.00%
00703476801	PACLITAXEL 300 MG/50 ML VIAL	PACLITAXEL	11.00%
00703476881	PACLITAXEL 300 MG/50 ML VIAL	PACLITAXEL	11.00%
25021021305	PACLITAXEL 30 MG/5 ML VIAL	PACLITAXEL	11.00%
25021021317	PACLITAXEL 100 MG/16.7 ML VIAL	PACLITAXEL	11.00%
25021021350	PACLITAXEL 300 MG/50 ML VIAL	PACLITAXEL	11.00%
44567050501	PACLITAXEL 100 MG/16.7 ML VIAL	PACLITAXEL	11.00%
44567050601	PACLITAXEL 300 MG/50 ML VIAL	PACLITAXEL	11.00%
45963061353	PACLITAXEL 100 MG/16.7 ML VIAL	PACLITAXEL	11.00%
45963061356	PACLITAXEL 30 MG/5 ML VIAL	PACLITAXEL	11.00%
45963061359	PACLITAXEL 300 MG/50 ML VIAL	PACLITAXEL	11.00%
55390011405	PACLITAXEL 30 MG/5 ML VIAL	PACLITAXEL	11.00%
55390011420	PACLITAXEL 100 MG/16.7 ML VIAL	PACLITAXEL	11.00%
55390011450	PACLITAXEL 300 MG/50 ML VIAL	PACLITAXEL	11.00%
55390030405	PACLITAXEL 30 MG/5 ML VIAL	PACLITAXEL	11.00%
55390030420	PACLITAXEL 100 MG/16.7 ML VIAL	PACLITAXEL	11.00%

55390030450	PACLITAXEL 300 MG/50 ML VIAL	PACLITAXEL	11.00%
55390031405	PACLITAXEL 30 MG/5 ML VIAL	PACLITAXEL	11.00%
55390031420	PACLITAXEL 100 MG/16.7 ML VIAL	PACLITAXEL	11.00%
55390031450	PACLITAXEL 300 MG/50 ML VIAL	PACLITAXEL	11.00%
61703034209	PACLITAXEL 30 MG/5 ML VIAL	PACLITAXEL	11.00%
61703034222	PACLITAXEL 100 MG/16.7 ML VIAL	PACLITAXEL	11.00%
61703034250	PACLITAXEL 300 MG/50 ML VIAL	PACLITAXEL	11.00%
63323076305	PACLITAXEL 30 MG/5 ML VIAL	PACLITAXEL	11.00%
63323076306	PACLITAXEL 30 MG/5 ML VIAL	PACLITAXEL	11.00%
63323076316	PACLITAXEL 100 MG/16.7 ML VIAL	PACLITAXEL	11.00%
63323076317	PACLITAXEL 100 MG/16.7 ML VIAL	PACLITAXEL	11.00%
63323076350	PACLITAXEL 300 MG/50 ML VIAL	PACLITAXEL	11.00%
63323076352	PACLITAXEL 300 MG/50 ML VIAL	PACLITAXEL	11.00%
66758004301	PACLITAXEL 30 MG/5 ML VIAL	PACLITAXEL	11.00%
66758004302	PACLITAXEL 100 MG/16.7 ML VIAL	PACLITAXEL	11.00%
66758004303	PACLITAXEL 300 MG/50 ML VIAL	PACLITAXEL	11.00%
00069010701	PAMIDRONATE 30 MG/10 ML VIAL	PAMIDRONATE DISODIUM	40.00%
00069010901	PAMIDRONATE 90 MG/10 ML VIAL	PAMIDRONATE DISODIUM	40.00%
00069018601	PAMIDRONATE 30 MG/10 ML VIAL	PAMIDRONATE DISODIUM	40.00%
00517074501	PAMIDRONATE 30 MG/10 ML VIAL	PAMIDRONATE DISODIUM	40.00%
00517074601	PAMIDRONATE 90 MG/10 ML VIAL	PAMIDRONATE DISODIUM	40.00%
00703407559	PAMIDRONATE 30 MG/10 ML VIAL	PAMIDRONATE DISODIUM	40.00%
00703408551	PAMIDRONATE 90 MG/10 ML VIAL	PAMIDRONATE DISODIUM	40.00%

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25021080210	PAMIDRONATE 30 MG/10 ML VIAL	PAMIDRONATE DISODIUM	40.00%
25021080310	PAMIDRONATE 90 MG/10 ML VIAL	PAMIDRONATE DISODIUM	40.00%
55390012701	PAMIDRONATE DISOD 30 MG VIAL	PAMIDRONATE DISODIUM	40.00%
55390012901	PAMIDRONATE DISOD 90 MG VIAL	PAMIDRONATE DISODIUM	40.00%
55390015701	PAMIDRONATE DISOD 30 MG VIAL	PAMIDRONATE DISODIUM	40.00%
55390015901	PAMIDRONATE DISOD 90 MG VIAL	PAMIDRONATE DISODIUM	40.00%
59923060110	PAMIDRONATE DISOD 30 MG VIAL	PAMIDRONATE DISODIUM	40.00%
59923060310	PAMIDRONATE DISOD 90 MG VIAL	PAMIDRONATE DISODIUM	40.00%
61703032418	PAMIDRONATE 30 MG/10 ML VIAL	PAMIDRONATE DISODIUM	40.00%
61703032518	PAMIDRONATE 60 MG/10 ML VIAL	PAMIDRONATE DISODIUM	40.00%
61703032618	PAMIDRONATE 90 MG/10 ML VIAL	PAMIDRONATE DISODIUM	40.00%
61703035618	PAMIDRONATE 90 MG/10 ML VIAL	PAMIDRONATE DISODIUM	40.00%
63323073410	PAMIDRONATE 30 MG/10 ML VIAL	PAMIDRONATE DISODIUM	40.00%
63323073510	PAMIDRONATE 90 MG/10 ML VIAL	PAMIDRONATE DISODIUM	40.00%
67457043010	PAMIDRONATE 30 MG/10 ML VIAL	PAMIDRONATE DISODIUM	40.00%
67457044610	PAMIDRONATE 90 MG/10 ML VIAL	PAMIDRONATE DISODIUM	40.00%
67457047210	PAMIDRONATE 30 MG/10 ML VIAL	PAMIDRONATE DISODIUM	40.00%
00093765656	PARICALCITOL 1 MCG CAPSULE	PARICALCITOL	16.00%
00093765756	PARICALCITOL 2 MCG CAPSULE	PARICALCITOL	16.00%
00093765856	PARICALCITOL 4 MCG CAPSULE	PARICALCITOL	16.00%
00409100701	PARICALCITOL 2 MCG/ML VIAL	PARICALCITOL	15.00%
00409100801	PARICALCITOL 5 MCG/ML VIAL	PARICALCITOL	15.00%
00409100802	PARICALCITOL 10 MCG/2 ML VIAL	PARICALCITOL	15.00%

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10888500102	PARICALCITOL 1 MCG CAPSULE	PARICALCITOL	16.00%
10888500202	PARICALCITOL 2 MCG CAPSULE	PARICALCITOL	16.00%
10888500302	PARICALCITOL 4 MCG CAPSULE	PARICALCITOL	16.00%
16729031008	PARICALCITOL 2 MCG/ML VIAL	PARICALCITOL	15.00%
16729031108	PARICALCITOL 5 MCG/ML VIAL	PARICALCITOL	15.00%
16729031193	PARICALCITOL 10 MCG/2 ML VIAL	PARICALCITOL	15.00%
55111066330	PARICALCITOL 1 MCG CAPSULE	PARICALCITOL	16.00%
55111066430	PARICALCITOL 2 MCG CAPSULE	PARICALCITOL	16.00%
55111066530	PARICALCITOL 4 MCG CAPSULE	PARICALCITOL	16.00%
60687010625	PARICALCITOL 1 MCG CAPSULE	PARICALCITOL	16.00%
68382026606	PARICALCITOL 1 MCG CAPSULE	PARICALCITOL	16.00%
68382026706	PARICALCITOL 2 MCG CAPSULE	PARICALCITOL	16.00%
69387010430	PARICALCITOL 2 MCG CAPSULE	PARICALCITOL	16.00%
69387010530	PARICALCITOL 4 MCG CAPSULE	PARICALCITOL	16.00%
55390024401	PENTOSTATIN 10 MG VIAL	PENTOSTATIN	40.00%
00074319716	MODERIBA 200 MG TABLET	RIBAVIRIN	88.63%
00074322456	MODERIBA 200-400 MG DOSEPACK	RIBAVIRIN	16.00%
00074323956	MODERIBA 400-400 MG DOSEPACK	RIBAVIRIN	15.00%
00074327156	MODERIBA 600-400 MG DOSEPACK	RIBAVIRIN	19.28%
00074328256	MODERIBA 600-600 MG DOSEPACK	RIBAVIRIN	21.05%
00093722758	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
00093722763	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
00093722772	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%

00093722777	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
00093723281	RIBAVIRIN 200 MG TABLET	RIBAVIRIN	88.63%
00781204304	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
00781204316	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
00781204342	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
00781204367	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
00781517728	RIBAVIRIN 200 MG TABLET	RIBAVIRIN	88.63%
54738095016	RIBAVIRIN 200 MG TABLET	RIBAVIRIN	88.63%
54738095318	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
54738095342	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
54738095356	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
54738095370	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
54738095384	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
54868452100	RIBASPHERE 200 MG CAPSULE	RIBAVIRIN	91.78%
54868452101	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
54868452102	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
54868452103	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
65862020768	RIBAVIRIN 200 MG TABLET	RIBAVIRIN	88.63%
65862029018	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
65862029042	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
65862029056	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
65862029070	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
65862029084	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%

66435010118	RIBASPHERE 200 MG CAPSULE	RIBAVIRIN	91.78%
66435010142	RIBASPHERE 200 MG CAPSULE	RIBAVIRIN	91.78%
66435010156	RIBASPHERE 200 MG CAPSULE	RIBAVIRIN	91.78%
66435010170	RIBASPHERE 200 MG CAPSULE	RIBAVIRIN	91.78%
66435010184	RIBASPHERE 200 MG CAPSULE	RIBAVIRIN	91.78%
66435010216	RIBASPHERE 200 MG TABLET	RIBAVIRIN	88.63%
66435010556	RIBASPHERE RIBAPAK 400-400 MG	RIBAVIRIN	16.00%
66435010599	RIBASPHERE RIBAPAK 400-400 MG	RIBAVIRIN	16.00%
66435010656	RIBASPHERE RIBAPAK 600-400 MG	RIBAVIRIN	19.28%
66435010699	RIBASPHERE RIBAPAK 600-400 MG	RIBAVIRIN	19.28%
66435010756	RIBASPHERE RIBAPAK 600-600 MG	RIBAVIRIN	21.05%
66435010799	RIBASPHERE RIBAPAK 600-600 MG	RIBAVIRIN	21.05%
68084015011	RIBAVIRIN 200 MG TABLET	RIBAVIRIN	88.63%
68084015065	RIBAVIRIN 200 MG TABLET	RIBAVIRIN	88.63%
68084017911	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
68084017965	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
68382004603	RIBAVIRIN 200 MG TABLET	RIBAVIRIN	88.63%
68382004610	RIBAVIRIN 200 MG TABLET	RIBAVIRIN	88.63%
68382004628	RIBAVIRIN 200 MG TABLET	RIBAVIRIN	88.63%
68382026004	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
68382026007	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
68382026009	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%
68382026012	RIBAVIRIN 200 MG CAPSULE	RIBAVIRIN	91.78%

00115300013	RILUZOLE 50 MG TABLET	RILUZOLE	83.02%
00378414591	RILUZOLE 50 MG TABLET	RILUZOLE	83.02%
60505328506	RILUZOLE 50 MG TABLET	RILUZOLE	83.02%
62756053886	RILUZOLE 50 MG TABLET	RILUZOLE	83.02%
64980019106	RILUZOLE 50 MG TABLET	RILUZOLE	83.02%
67877028660	RILUZOLE 50 MG TABLET	RILUZOLE	83.02%
68462038160	RILUZOLE 50 MG TABLET	RILUZOLE	83.02%
00093551798	SILDENAFIL 20 MG TABLET	SILDENAFIL CITRATE	90.98%
00378165777	SILDENAFIL 20 MG TABLET	SILDENAFIL CITRATE	90.98%
00591378019	SILDENAFIL 20 MG TABLET	SILDENAFIL CITRATE	90.98%
13668018505	SILDENAFIL 20 MG TABLET	SILDENAFIL CITRATE	90.98%
13668018590	SILDENAFIL 20 MG TABLET	SILDENAFIL CITRATE	90.98%
16714033801	SILDENAFIL 20 MG TABLET	SILDENAFIL CITRATE	90.98%
31722077690	SILDENAFIL 20 MG TABLET	SILDENAFIL CITRATE	90.98%
33342012110	SILDENAFIL 20 MG TABLET	SILDENAFIL CITRATE	90.98%
55111037290	SILDENAFIL 20 MG TABLET	SILDENAFIL CITRATE	90.98%
59762003301	SILDENAFIL 20 MG TABLET	SILDENAFIL CITRATE	90.98%
60505340405	SILDENAFIL 20 MG TABLET	SILDENAFIL CITRATE	90.98%
60505340409	SILDENAFIL 20 MG TABLET	SILDENAFIL CITRATE	90.98%
65162035109	SILDENAFIL 20 MG TABLET	SILDENAFIL CITRATE	90.98%
68001017605	SILDENAFIL 20 MG TABLET	SILDENAFIL CITRATE	90.98%
68084062221	SILDENAFIL 20 MG TABLET	SILDENAFIL CITRATE	90.98%
68084086921	SILDENAFIL 20 MG TABLET	SILDENAFIL CITRATE	90.98%

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55111065301	SIROLIMUS 1 MG TABLET	SIROLIMUS	20.00%
55111065401	SIROLIMUS 2 MG TABLET	SIROLIMUS	20.00%
59762100101	SIROLIMUS 0.5 MG TABLET	SIROLIMUS	16.00%
59762100201	SIROLIMUS 1 MG TABLET	SIROLIMUS	20.00%
59762100301	SIROLIMUS 2 MG TABLET	SIROLIMUS	20.00%
68084095625	SIROLIMUS 0.5 MG TABLET	SIROLIMUS	16.00%
68382052001	SIROLIMUS 0.5 MG TABLET	SIROLIMUS	16.00%
00378504091	STAVUDINE 15 MG CAPSULE	STAVUDINE	37.64%
00378504191	STAVUDINE 20 MG CAPSULE	STAVUDINE	57.90%
00378504291	STAVUDINE 30 MG CAPSULE	STAVUDINE	51.45%
00378504391	STAVUDINE 40 MG CAPSULE	STAVUDINE	67.72%
31722051560	STAVUDINE 15 MG CAPSULE	STAVUDINE	37.64%
31722051660	STAVUDINE 20 MG CAPSULE	STAVUDINE	57.90%
31722051760	STAVUDINE 30 MG CAPSULE	STAVUDINE	51.45%
31722051860	STAVUDINE 40 MG CAPSULE	STAVUDINE	67.72%
42799011301	STAVUDINE 1 MG/ML SOLUTION	STAVUDINE	16.00%
54569612300	STAVUDINE 40 MG CAPSULE	STAVUDINE	67.72%
54569620600	STAVUDINE 30 MG CAPSULE	STAVUDINE	51.45%
65862004660	STAVUDINE 30 MG CAPSULE	STAVUDINE	51.45%
65862004760	STAVUDINE 40 MG CAPSULE	STAVUDINE	67.72%
65862011160	STAVUDINE 15 MG CAPSULE	STAVUDINE	37.64%
65862011260	STAVUDINE 20 MG CAPSULE	STAVUDINE	57.90%
68084046011	STAVUDINE 40 MG CAPSULE	STAVUDINE	67.72%

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68084046021	STAVUDINE 40 MG CAPSULE	STAVUDINE	67.72%
00078061605	HECORIA 0.5 MG CAPSULE	TACROLIMUS	16.00%
00078061705	HECORIA 1 MG CAPSULE	TACROLIMUS	33.57%
00078061805	HECORIA 5 MG CAPSULE	TACROLIMUS	51.89%
00378204501	TACROLIMUS 0.5 MG CAPSULE	TACROLIMUS	16.00%
00378204505	TACROLIMUS 0.5 MG CAPSULE	TACROLIMUS	16.00%
00378204601	TACROLIMUS 1 MG CAPSULE	TACROLIMUS	33.57%
00378204605	TACROLIMUS 1 MG CAPSULE	TACROLIMUS	33.57%
00378204701	TACROLIMUS 5 MG CAPSULE	TACROLIMUS	51.89%
00378204705	TACROLIMUS 5 MG CAPSULE	TACROLIMUS	51.89%
00781210201	TACROLIMUS 0.5 MG CAPSULE	TACROLIMUS	16.00%
00781210301	TACROLIMUS 1 MG CAPSULE	TACROLIMUS	33.57%
00781210401	TACROLIMUS 5 MG CAPSULE	TACROLIMUS	51.89%
00781930201	TACROLIMUS 0.5 MG CAPSULE	TACROLIMUS	16.00%
00781930301	TACROLIMUS 1 MG CAPSULE	TACROLIMUS	33.57%
00781930401	TACROLIMUS 5 MG CAPSULE	TACROLIMUS	51.89%
16729004101	TACROLIMUS 0.5 MG CAPSULE	TACROLIMUS	16.00%
16729004201	TACROLIMUS 1 MG CAPSULE	TACROLIMUS	33.57%
16729004301	TACROLIMUS 5 MG CAPSULE	TACROLIMUS	51.89%
43353017853	PROGRAF 1 MG CAPSULE	TACROLIMUS	33.57%
43353017860	PROGRAF 1 MG CAPSULE	TACROLIMUS	33.57%
43353017880	PROGRAF 1 MG CAPSULE	TACROLIMUS	33.57%
50742020701	TACROLIMUS 0.5 MG CAPSULE	TACROLIMUS	16.00%

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50742020801	TACROLIMUS 1 MG CAPSULE	TACROLIMUS	33.57%
50742020901	TACROLIMUS 5 MG CAPSULE	TACROLIMUS	51.89%
51079002801	TACROLIMUS 5 MG CAPSULE	TACROLIMUS	51.89%
51079002820	TACROLIMUS 5 MG CAPSULE	TACROLIMUS	51.89%
51079081701	TACROLIMUS 0.5 MG CAPSULE	TACROLIMUS	16.00%
51079081720	TACROLIMUS 0.5 MG CAPSULE	TACROLIMUS	16.00%
51079081801	TACROLIMUS 1 MG CAPSULE	TACROLIMUS	33.57%
51079081820	TACROLIMUS 1 MG CAPSULE	TACROLIMUS	33.57%
55111052501	TACROLIMUS 0.5 MG CAPSULE	TACROLIMUS	16.00%
55111052601	TACROLIMUS 1 MG CAPSULE	TACROLIMUS	33.57%
55111052701	TACROLIMUS 5 MG CAPSULE	TACROLIMUS	51.89%
62175038037	TACROLIMUS 0.5 MG CAPSULE	TACROLIMUS	16.00%
62175038137	TACROLIMUS 1 MG CAPSULE	TACROLIMUS	33.57%
62175038237	TACROLIMUS 5 MG CAPSULE	TACROLIMUS	51.89%
68084044901	TACROLIMUS 0.5 MG CAPSULE	TACROLIMUS	16.00%
68084044911	TACROLIMUS 0.5 MG CAPSULE	TACROLIMUS	16.00%
68084045001	TACROLIMUS 1 MG CAPSULE	TACROLIMUS	33.57%
68084045011	TACROLIMUS 1 MG CAPSULE	TACROLIMUS	33.57%
68084045101	TACROLIMUS 5 MG CAPSULE	TACROLIMUS	51.89%
68084045111	TACROLIMUS 5 MG CAPSULE	TACROLIMUS	51.89%
69452015320	TACROLIMUS 0.5 MG CAPSULE	TACROLIMUS	16.00%
69452015420	TACROLIMUS 1 MG CAPSULE	TACROLIMUS	33.57%
69452015520	TACROLIMUS 5 MG CAPSULE	TACROLIMUS	51.89%

00054032003	TEMOZOLOMIDE 5 MG CAPSULE	TEMOZOLOMIDE	16.00%
00054032006	TEMOZOLOMIDE 5 MG CAPSULE	TEMOZOLOMIDE	16.00%
00054032103	TEMOZOLOMIDE 20 MG CAPSULE	TEMOZOLOMIDE	16.00%
00054032106	TEMOZOLOMIDE 20 MG CAPSULE	TEMOZOLOMIDE	16.00%
00054032203	TEMOZOLOMIDE 100 MG CAPSULE	TEMOZOLOMIDE	26.90%
00054032206	TEMOZOLOMIDE 100 MG CAPSULE	TEMOZOLOMIDE	26.90%
00054032303	TEMOZOLOMIDE 140 MG CAPSULE	TEMOZOLOMIDE	24.74%
00054032306	TEMOZOLOMIDE 140 MG CAPSULE	TEMOZOLOMIDE	24.74%
00054032403	TEMOZOLOMIDE 180 MG CAPSULE	TEMOZOLOMIDE	29.35%
00054032406	TEMOZOLOMIDE 180 MG CAPSULE	TEMOZOLOMIDE	29.35%
00054032503	TEMOZOLOMIDE 250 MG CAPSULE	TEMOZOLOMIDE	25.70%
00093759941	TEMOZOLOMIDE 5 MG CAPSULE	TEMOZOLOMIDE	16.00%
00093759957	TEMOZOLOMIDE 5 MG CAPSULE	TEMOZOLOMIDE	16.00%
00093760041	TEMOZOLOMIDE 20 MG CAPSULE	TEMOZOLOMIDE	16.00%
00093760057	TEMOZOLOMIDE 20 MG CAPSULE	TEMOZOLOMIDE	16.00%
00093760141	TEMOZOLOMIDE 100 MG CAPSULE	TEMOZOLOMIDE	26.90%
00093760157	TEMOZOLOMIDE 100 MG CAPSULE	TEMOZOLOMIDE	26.90%
00093760257	TEMOZOLOMIDE 250 MG CAPSULE	TEMOZOLOMIDE	25.70%
00093763841	TEMOZOLOMIDE 140 MG CAPSULE	TEMOZOLOMIDE	24.74%
00093763857	TEMOZOLOMIDE 140 MG CAPSULE	TEMOZOLOMIDE	24.74%
00093763941	TEMOZOLOMIDE 180 MG CAPSULE	TEMOZOLOMIDE	29.35%
00093763957	TEMOZOLOMIDE 180 MG CAPSULE	TEMOZOLOMIDE	29.35%
00781269144	TEMOZOLOMIDE 5 MG CAPSULE	TEMOZOLOMIDE	16.00%

00781269175	TEMOZOLOMIDE 5 MG CAPSULE	TEMOZOLOMIDE	16.00%
00781269244	TEMOZOLOMIDE 20 MG CAPSULE	TEMOZOLOMIDE	16.00%
00781269275	TEMOZOLOMIDE 20 MG CAPSULE	TEMOZOLOMIDE	16.00%
00781269344	TEMOZOLOMIDE 100 MG CAPSULE	TEMOZOLOMIDE	26.90%
00781269375	TEMOZOLOMIDE 100 MG CAPSULE	TEMOZOLOMIDE	26.90%
00781269444	TEMOZOLOMIDE 140 MG CAPSULE	TEMOZOLOMIDE	24.74%
00781269475	TEMOZOLOMIDE 140 MG CAPSULE	TEMOZOLOMIDE	24.74%
00781269544	TEMOZOLOMIDE 180 MG CAPSULE	TEMOZOLOMIDE	29.35%
00781269575	TEMOZOLOMIDE 180 MG CAPSULE	TEMOZOLOMIDE	29.35%
00781269675	TEMOZOLOMIDE 250 MG CAPSULE	TEMOZOLOMIDE	25.70%
43975025214	TEMOZOLOMIDE 5 MG CAPSULE	TEMOZOLOMIDE	16.00%
43975025305	TEMOZOLOMIDE 20 MG CAPSULE	TEMOZOLOMIDE	16.00%
43975025314	TEMOZOLOMIDE 20 MG CAPSULE	TEMOZOLOMIDE	16.00%
43975025405	TEMOZOLOMIDE 100 MG CAPSULE	TEMOZOLOMIDE	26.90%
43975025414	TEMOZOLOMIDE 100 MG CAPSULE	TEMOZOLOMIDE	26.19%
43975025505	TEMOZOLOMIDE 140 MG CAPSULE	TEMOZOLOMIDE	24.74%
43975025514	TEMOZOLOMIDE 140 MG CAPSULE	TEMOZOLOMIDE	24.74%
43975025605	TEMOZOLOMIDE 180 MG CAPSULE	TEMOZOLOMIDE	29.35%
43975025614	TEMOZOLOMIDE 180 MG CAPSULE	TEMOZOLOMIDE	29.35%
43975025705	TEMOZOLOMIDE 250 MG CAPSULE	TEMOZOLOMIDE	25.70%
47335089021	TEMOZOLOMIDE 5 MG CAPSULE	TEMOZOLOMIDE	16.00%
47335089080	TEMOZOLOMIDE 5 MG CAPSULE	TEMOZOLOMIDE	16.00%
47335089121	TEMOZOLOMIDE 20 MG CAPSULE	TEMOZOLOMIDE	16.00%

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47335089180	TEMOZOLOMIDE 20 MG CAPSULE	TEMOZOLOMIDE	16.00%
47335089221	TEMOZOLOMIDE 100 MG CAPSULE	TEMOZOLOMIDE	26.90%
47335089280	TEMOZOLOMIDE 100 MG CAPSULE	TEMOZOLOMIDE	26.90%
47335089380	TEMOZOLOMIDE 250 MG CAPSULE	TEMOZOLOMIDE	25.70%
47335092921	TEMOZOLOMIDE 140 MG CAPSULE	TEMOZOLOMIDE	24.74%
47335092980	TEMOZOLOMIDE 140 MG CAPSULE	TEMOZOLOMIDE	24.74%
47335093021	TEMOZOLOMIDE 180 MG CAPSULE	TEMOZOLOMIDE	29.35%
47335093080	TEMOZOLOMIDE 180 MG CAPSULE	TEMOZOLOMIDE	29.35%
65162080114	TEMOZOLOMIDE 5 MG CAPSULE	TEMOZOLOMIDE	16.00%
65162080151	TEMOZOLOMIDE 5 MG CAPSULE	TEMOZOLOMIDE	16.00%
65162080214	TEMOZOLOMIDE 20 MG CAPSULE	TEMOZOLOMIDE	16.00%
65162080251	TEMOZOLOMIDE 20 MG CAPSULE	TEMOZOLOMIDE	16.00%
65162080314	TEMOZOLOMIDE 100 MG CAPSULE	TEMOZOLOMIDE	26.90%
65162080351	TEMOZOLOMIDE 100 MG CAPSULE	TEMOZOLOMIDE	26.90%
65162080414	TEMOZOLOMIDE 140 MG CAPSULE	TEMOZOLOMIDE	24.74%
65162080451	TEMOZOLOMIDE 140 MG CAPSULE	TEMOZOLOMIDE	24.74%
65162080551	TEMOZOLOMIDE 180 MG CAPSULE	TEMOZOLOMIDE	29.35%
65162080651	TEMOZOLOMIDE 250 MG CAPSULE	TEMOZOLOMIDE	25.70%
44567050701	TENIPOSIDE 50 MG/5 ML AMPULE	TENIPOSIDE	40.00%
31722082111	TETRABENAZINE 12.5 MG TABLET	TETRABENAZINE	20.00%
31722082211	TETRABENAZINE 25 MG TABLET	TETRABENAZINE	20.00%
00143956501	THIOTEPA 15 MG VIAL	THIOTEPA	40.00%
55390003010	THIOTEPA 15 MG VIAL	THIOTEPA	40.00%

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00781717156	TOBRAMYCIN 300 MG/5 ML AMPULE	TOBRAMYCIN/0.25 NORMAL SALINE	22.87%
17478034038	TOBRAMYCIN 300 MG/5 ML AMPULE	TOBRAMYCIN/0.25 NORMAL SALINE	22.87%
00069007501	TOPOTECAN HCL 4 MG VIAL	TOPOTECAN HCL	40.00%
00409030225	TOPOTECAN HCL 4 MG/4 ML VIAL	TOPOTECAN HCL	40.00%
00703471401	TOPOTECAN HCL 4 MG/4 ML VIAL	TOPOTECAN HCL	40.00%
00703471471	TOPOTECAN HCL 4 MG/4 ML VIAL	TOPOTECAN HCL	40.00%
16729015131	TOPOTECAN HCL 4 MG VIAL	TOPOTECAN HCL	40.00%
25021020606	TOPOTECAN HCL 4 MG VIAL	TOPOTECAN HCL	40.00%
25021020661	TOPOTECAN HCL 4 MG VIAL	TOPOTECAN HCL	40.00%
25021023604	TOPOTECAN HCL 4 MG/4 ML VIAL	TOPOTECAN HCL	40.00%
25021082406	TOPOTECAN HCL 4 MG VIAL	TOPOTECAN HCL	40.00%
45963061556	TOPOTECAN HCL 4 MG VIAL	TOPOTECAN HCL	40.00%
55390037010	TOPOTECAN HCL 4 MG VIAL	TOPOTECAN HCL	40.00%
62756002340	TOPOTECAN HCL 4 MG VIAL	TOPOTECAN HCL	40.00%
63323076210	TOPOTECAN HCL 4 MG VIAL	TOPOTECAN HCL	40.00%
63323076217	TOPOTECAN HCL 4 MG VIAL	TOPOTECAN HCL	40.00%
63323076294	TOPOTECAN HCL 4 MG VIAL	TOPOTECAN HCL	40.00%
66435041005	TOPOTECAN HCL 4 MG VIAL	TOPOTECAN HCL	40.00%
60505363801	TRANEXAMIC ACID 650 MG TABLET	TRANEXAMIC ACID	21.00%
60505363803	TRANEXAMIC ACID 650 MG TABLET	TRANEXAMIC ACID	21.00%
69918030130	TRANEXAMIC ACID 650 MG TABLET	TRANEXAMIC ACID	21.00%
00310781030	VANDETANIB 100 MG TABLET	VANDETANIB	40.00%
00310783030	VANDETANIB 300 MG TABLET	VANDETANIB	40.00%

50242009002	ZELBORAF 240 MG TABLET	VEMURAFENIB	13.54%
55390009110	VINBLASTINE SULF 10 MG VIAL	VINBLASTINE SULFATE	40.00%
63323027810	VINBLASTINE 1 MG/ML VIAL	VINBLASTINE SULFATE	40.00%
00703440211	VINCASAR PFS 1 MG/ML VIAL	VINCRISTINE SULFATE	40.00%
00703441211	VINCASAR PFS 2 MG/2 ML VIAL	VINCRISTINE SULFATE	11.98%
61703030906	VINCRISTINE 1 MG/ML VIAL	VINCRISTINE SULFATE	40.00%
61703030916	VINCRISTINE 2 MG/2 ML VIAL	VINCRISTINE SULFATE	11.98%
61703030925	VINCRISTINE 2 MG/2 ML VIAL	VINCRISTINE SULFATE	11.98%
61703030926	VINCRISTINE 1 MG/ML VIAL	VINCRISTINE SULFATE	40.00%
00069009901	VINORELBINE 10 MG/ML VIAL	VINORELBINE TARTRATE	40.00%
00069010303	VINORELBINE 50 MG/5 ML VIAL	VINORELBINE TARTRATE	40.00%
00069020510	VINORELBINE 10 MG/ML VIAL	VINORELBINE TARTRATE	40.00%
00069020550	VINORELBINE 50 MG/5 ML VIAL	VINORELBINE TARTRATE	40.00%
00703418201	VINORELBINE 10 MG/ML VIAL	VINORELBINE TARTRATE	40.00%
00703418291	VINORELBINE 10 MG/ML VIAL	VINORELBINE TARTRATE	40.00%
00703418301	VINORELBINE 50 MG/5 ML VIAL	VINORELBINE TARTRATE	40.00%
00703418391	VINORELBINE 50 MG/5 ML VIAL	VINORELBINE TARTRATE	40.00%
25021020401	VINORELBINE 10 MG/ML VIAL	VINORELBINE TARTRATE	40.00%
25021020405	VINORELBINE 50 MG/5 ML VIAL	VINORELBINE TARTRATE	40.00%
45963060755	VINORELBINE 10 MG/ML VIAL	VINORELBINE TARTRATE	40.00%
45963060756	VINORELBINE 50 MG/5 ML VIAL	VINORELBINE TARTRATE	40.00%
55390006901	VINORELBINE 10 MG/ML VIAL	VINORELBINE TARTRATE	40.00%
55390007001	VINORELBINE 50 MG/5 ML VIAL	VINORELBINE TARTRATE	40.00%

61703034106	VINORELBINE 10 MG/ML VIAL	VINORELBINE TARTRATE	40.00%
61703034109	VINORELBINE 50 MG/5 ML VIAL	VINORELBINE TARTRATE	40.00%
63323014801	VINORELBINE 10 MG/ML VIAL	VINORELBINE TARTRATE	40.00%
63323014805	VINORELBINE 50 MG/5 ML VIAL	VINORELBINE TARTRATE	40.00%
66758004501	VINORELBINE 10 MG/ML VIAL	VINORELBINE TARTRATE	40.00%
66758004502	VINORELBINE 50 MG/5 ML VIAL	VINORELBINE TARTRATE	40.00%
67457043111	VINORELBINE 10 MG/ML VIAL	VINORELBINE TARTRATE	40.00%
00054005221	ZIDOVUDINE 300 MG TABLET	ZIDOVUDINE	88.36%
00378610691	ZIDOVUDINE 300 MG TABLET	ZIDOVUDINE	88.36%
21695036918	ZIDOVUDINE 300 MG TABLET	ZIDOVUDINE	88.36%
31722050960	ZIDOVUDINE 300 MG TABLET	ZIDOVUDINE	88.36%
42799040301	ZIDOVUDINE 100 MG CAPSULE	ZIDOVUDINE	16.00%
42799040401	ZIDOVUDINE 50 MG/5 ML SYRUP	ZIDOVUDINE	16.00%
52343004401	ZIDOVUDINE 100 MG CAPSULE	ZIDOVUDINE	16.00%
52343004560	ZIDOVUDINE 300 MG TABLET	ZIDOVUDINE	88.36%
54569617100	ZIDOVUDINE 300 MG TABLET	ZIDOVUDINE	88.36%
65862002460	ZIDOVUDINE 300 MG TABLET	ZIDOVUDINE	88.36%
65862004824	ZIDOVUDINE 50 MG/5 ML SYRUP	ZIDOVUDINE	16.00%
65862010701	ZIDOVUDINE 100 MG CAPSULE	ZIDOVUDINE	16.00%
68084046111	ZIDOVUDINE 100 MG CAPSULE	ZIDOVUDINE	16.00%
68084046121	ZIDOVUDINE 100 MG CAPSULE	ZIDOVUDINE	16.00%
68084046211	ZIDOVUDINE 300 MG TABLET	ZIDOVUDINE	88.36%
68084046221	ZIDOVUDINE 300 MG TABLET	ZIDOVUDINE	88.36%

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00143964201	ZOLEDRONIC ACID 4 MG/5 ML VIAL	ZOLEDRONIC ACID	15.00%
23155017031	ZOLEDRONIC ACID 4 MG/5 ML VIAL	ZOLEDRONIC ACID	15.00%
25021080166	ZOLEDRONIC ACID 4 MG/5 ML VIAL	ZOLEDRONIC ACID	15.00%
42023015101	ZOLEDRONIC ACID 4 MG/5 ML VIAL	ZOLEDRONIC ACID	15.00%
43598033011	ZOLEDRONIC ACID 4 MG/5 ML VIAL	ZOLEDRONIC ACID	15.00%
45963044055	ZOLEDRONIC ACID 4 MG/5 ML VIAL	ZOLEDRONIC ACID	15.00%
47335003540	ZOLEDRONIC ACID 4 MG/5 ML VIAL	ZOLEDRONIC ACID	15.00%
53150087101	ZOLEDRONIC ACID 4 MG/5 ML VIAL	ZOLEDRONIC ACID	15.00%
55111068507	ZOLEDRONIC ACID 4 MG/5 ML VIAL	ZOLEDRONIC ACID	15.00%
60505611000	ZOLEDRONIC ACID 4 MG/5 ML VIAL	ZOLEDRONIC ACID	15.00%
63323096198	ZOLEDRONIC ACID 4 MG/5 ML VIAL	ZOLEDRONIC ACID	15.00%
67457039054	ZOLEDRONIC ACID 4 MG/5 ML VIAL	ZOLEDRONIC ACID	15.00%
25021082666	ZOLEDRONIC ACID 4 MG/100 ML	ZOLEDRONIC ACID/MANNITOL&WATER	15.00%
25021082667	ZOLEDRONIC ACID 4 MG/100 ML	ZOLEDRONIC ACID/MANNITOL&WATER	15.00%
25021082682	ZOLEDRONIC ACID 4 MG/100 ML	ZOLEDRONIC ACID/MANNITOL&WATER	15.00%
25021083082	ZOLEDRONIC ACID 5 MG/100 ML	ZOLEDRONIC ACID/MANNITOL&WATER	15.00%
23155018631	ZOLEDRONIC ACID 5 MG/100 ML	ZOLEDRONIC ACID/MANNITOL/WATER	21.00%
42023016301	ZOLEDRONIC ACID 5 MG/100 ML	ZOLEDRONIC ACID/MANNITOL/WATER	21.00%
43598033111	ZOLEDRONIC ACID 5 MG/100 ML	ZOLEDRONIC ACID/MANNITOL/WATER	21.00%
55111068852	ZOLEDRONIC ACID 5 MG/100 ML	ZOLEDRONIC ACID/MANNITOL/WATER	21.00%

EXHIBIT F

Administrative Services Only Agreement

By and Between

[redacted]

"Employer"

And

Connecticut General Life Insurance Company
"Connecticut General"

Effective Date: October 1, 2010

THIS AGREEMENT AND ITS TERMS ARE PROPRIETARY AND CANNOT BE DISCLOSED WITHOUT THE PERMISSION OF EACH OF THE PARTIES

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ATTORNEYS' EYES ONLY

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Customer Name: [redacted]
Administrative Services Only Agreement

Schedule of Financial Charges

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

	MEDICAL/DENTAL ADMINISTRATION CHARGES (Includes Commission payments agreed to by Employer)	
Product	**Description**	**Charge**
Medical	• Open Access Plus (OAP) with PHS Medical Management	**$49.71/employee/month**
Medical	• Commissions	**$10.49/employee/month**
Vision	• CIGNA VisionCare	**$0.99/employee/month**
Dental	• Dental Preferred Provider Organization (DPPO)	**$3.21/employee/month**
Dental	• Commissions	**$0.90/employee/month**
	MEDICAL/DENTAL NETWORK ACCESS FEE	
Product	**Description**	**Charge**
Medical	• OAP Access Fee	**$10.52/employee/month**
Dental	• Dental PPO Access Fee	**$0.70/employee/month**
	PHARMACY ADMINISTRATION CHARGES	
	Product	**Charge**
Pharmacy	• CG Pharmacy	**Included in Medical Administration Fee**

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ATTORNEYS' EYES ONLY

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Customer Name: [redacted]
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CIGNA Tel-Drug	Connecticut General will charge Employer, as stated in the column at right, for the following categories of covered drugs dispensed from the CIGNA Tel-Drug mail order pharmacy: (i) brand drugs; (ii) generic drugs; and (iii) Specialty Drugs, which are generally injectable or infused drugs as determined by Connecticut General in accordance with industry practice. Classification of brand or generic is made in accordance with generally-accepted industry standards or practices adopted by Connecticut General. CIGNA Tel-Drug will retain the margin or absorb the deficit between such charge and its acquisition cost for the drug. CIGNA Tel-Drug's discounts are applied to the manufacturer average wholesale price (AWP) for the dispensed size (or to the AWP for the manufacturer-packaged quantity closest to the dispensed size, if there is no AWP for the dispensed size). The charge may be different where made by a participating home health care provider with which CIGNA Tel-Drug has contracted to supply Specialty Drugs.	**Brand drugs at mail (including generics within their exclusivity period or other period of limited competition):** **AWP minus 17% plus $0.00 dispensing fee.** **Generic drugs at mail (other than those to which the above brand discount applies):** **The lesser of (i) the drug's charge on a generic Maximum Allowable Charge schedule that generates an average aggregate discount of between, at a minimum, AWP minus 64% and AWP minus 68% (individual client experience may be superior based upon case specifics) plus a $0.00 dispensing fee; or (ii) the pharmacy's usual and customary charge.**

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ATTORNEYS' EYES ONLY

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CIGNA Tel-Drug *(continued from previous page)*		**Specialty Drugs at mail:** **AWP minus an average aggregate discount across CIGNA Tel-Drug's group customers of at least 10%.**
Explanatory Note Regarding "AWP"	Changes in Market Conditions; Average Wholesale Price. Notwithstanding any other provision in this Agreement, including in this Exhibit, in the event of any major change in market conditions affecting the pharmaceutical or pharmacy benefit management market, including, for example, any change in the markup, methodologies, processes or algorithms underlying the published AWP(s), Connecticut General may adjust any or all of the charges, rates, discounts, guarantees and/or fees in connection with Connecticut General's administration of the plan's retail and mail order pharmacy benefit hereunder, including any that are based on AWP, as it reasonably deems necessary to preserve the economic value or benefit of this Agreement as it existed immediately prior to such change. Additionally, and notwithstanding any other provision in this Agreement, including in this Exhibit, Connecticut General may replace AWP as its pharmaceutical pricing benchmark with an alternative benchmark and/or may replace First DataBank as its source for the AWP or alternative benchmark with a different pricing source, provided that Connecticut General adjusts any or all such AWP-Based Charges or such alternative benchmark-based charges as it reasonably deems necessary to preserve the economic value or benefit of this Agreement as it existed immediately prior to such replacement or immediately prior to the event(s) giving rise to such replacement, as the case may be.	

Cigna_TML00125176

ATTORNEYS' EYES ONLY

Customer Name: [redacted]
Administrative Services Only Agreement

Retail Pharmacy Ingredient Cost Charges for Generic Drugs	Connecticut General will charge Employer as stated in the column at right for the ingredient cost of covered generic drugs dispensed from participating retail pharmacies (other than generics within their exclusivity period or other period of limited competition). Classification of brand or generic is made in accordance with generally-accepted industry standards or practices adopted by Connecticut General. Connecticut General will retain the positive margin or absorb the negative margin, as applicable, between such charge and the payment that Connecticut General makes to the retail pharmacy for the ingredient cost for the generic drug.	**The lesser of:** **(i) the drug's charge on a generic Maximum Allowable Charge schedule that generates an average aggregate discount of between, at a minimum, AWP minus 64% and AWP minus 68% (individual Employer experience may be superior based upon case specifics); or** **(ii) the pharmacy's usual and customary charge.**
Retail Pharmacy Charges for Specialty Drugs	Connecticut General will charge Employer as stated in the column at right for covered Specialty Drugs (which are generally injectable or infused drugs and determined by Connecticut General in accordance with industry practice) dispensed from participating retail pharmacies. Connecticut General will retain the positive margin or absorb the negative margin, as applicable, between such charge and the payment that Connecticut General makes to the retail pharmacy for the Specialty Drug.	**The lesser of:** **(i) AWP minus an average aggregate discount across specialty prescriptions dispensed at retail to Connecticut General's group client book of business of at least 10%; or (ii) the pharmacy's usual and customary charge.**
Communications to Participants	Connecticut General and CIGNA Tel-Drug may contact Participants and providers in support of the administration of the Plan, including contacting them in an effort to increase their awareness of the formulary and CIGNA Tel-Drug's availability.	
Reimbursement to CIGNA Tel-Drug for Replacement Prescriptions	CIGNA Tel-Drug will be reimbursed through the Bank Account for the price (discounted as per this Schedule) for replacement prescriptions shipped by CIGNA Tel-Drug which are reported as lost or damaged despite CIGNA Tel-Drug's shipment to the Participant's correct name and address.	

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FEES FOR PROCESSING RUN-OUT CLAIMS		
OAP, CIGNA VisionCare and Dental PPO	Run-Out Period of twelve (12) months Connecticut General shall not be required to process Run-Out Claims until it has received full payment of the required fees.	**The sum of the last four (4) months of billed fees applicable to the terminated (i) Agreement, (ii) Plan benefit option or (iii) Members.**
Pharmacy	Run-Out Period of three (3) months for all pharmacy claims Connecticut General shall not be required to process Run-Out Claims until it has received full payment of the required fees.	**The sum of the last three (3) months of billed fees applicable to the terminated (i) Agreement, (ii) Plan benefit option or (iii) Members.**
SUBROGATION		
	Subrogation/Conditional Claim Payment (Medical Only)	**5% of recovery plus litigation costs if Counsel is retained; 29% of recovery if no Counsel is retained. Notwithstanding any other amount reflected in the Conditional Claim/Subrogation Recovery Services Exhibit.**

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COST CONTAINMENT FEES		
Connecticut General, a CIGNA company, administers the following programs to contain costs with respect to charges for health care service/supplies that are covered by the Plan. In administering these programs, Connecticut General contracts with vendors to perform program related services. Specific vendor fees are available upon request. Connecticut General's charge for administering these programs is the percentage (indicated below) of either (1) the "net savings" (i.e. the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings, less the applicable vendor fee which generally ranges from 7-11% of the program savings) or (2) the "gross savings" (i.e. the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings; Connecticut General pays the applicable vendor fee), or (3) the "recovery" (i.e. the amount recovered) as applicable. For covered services received from non-participating providers, Connecticut General will apply discounts available under agreements with third parties or through negotiation of the billed charges. These programs are identified below as the Network Savings Program, Supplemental Network & Medical Bill Review (pre-payment). This is consistent with the claim administration practices applicable to Connecticut General's' own health care insurance business when these programs are implemented. Connecticut General charges the percentage shown for administering these programs. Applying these discounts may result in higher payments than if the maximum reimbursable charge is applied. Whereas application of the maximum reimbursable charge may result in the patient being balance billed for the entire unreimbursed amount, applying these discounts avoids balance billing and substantially reduces the patient's out-of pocket cost. The Dental Network Savings Program is not yet operational and the scheduled implementation date will be announced in 2010.		
MEDICAL AND PHARMACY COST CONTAINMENT		
1.	Network Savings Program	**29% of net savings**
2.	Supplemental Network	**29% of net savings**
3.	Medical Bill Review – (Pre-payment Cost Containment for Non-contracted claims):	
	Inpatient Hospital Bill Review	
	• Line Item Analysis	**Lesser of 5% of hospital bill or the savings achieved**
	• Professional Fee Negotiation	**29% of net savings**
	Outpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
	Physician/Professional Bill Review	
	• Professional Fee Negotiation	**29% of net savings**

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4.	Medical Bill Review – (Pre or Post-payment Cost Containment for Non-contracted and Contracted claims):	
	Inpatient Hospital Bill Review	
	• Hospital Bill Audit	**29% of the savings/recovery achieved plus hospital fees or expenses passed through**
	Physician/Professional Fee Bill Audit (where available)	**Specific charge information available upon request.**
	DRG Validation and Appeals	**29% of recovery plus any fees or expenses passed through by the hospital or regulatory agency**
	Inpatient Admission Retrospective Review	**29% of recovery**
	Medical Implant Device Audits	**29% of recovery**
5.	COB Vendor Recoveries [Exclusive of pharmacy programs where claims are adjudicated at time prescription is received.]	**29% of recovery**
6.	Secondary Vendor Recovery Program	**29% of recovery**
7.	Provider Credit Balance Recovery Program	**29% of recovery**
8.	High Cost Specialty Pharmaceutical Audits	**29% of recovery**
9.	Pharmacy Vendor Recoveries	**30% of recovery**
10.	Class Action Recoveries	**35% of recovery**
	DENTAL COST CONTAINMENT	
1.	Network Savings Program	**35% of gross savings**
	ELIGIBILITY OVERPAYMENT RECOVERY FEES	
	Eligibility Overpayment Recovery Vendor Services	**29% of recovery**

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EXTERNAL REVIEW PROGRAM FEES		
	The range of External Review charges is dependent on the nature and complexity of the appeal. In highly complex, non-routine cases or cases related to new technology or experimental-investigational treatment, a panel of reviewers may be necessary. External Review charges will be commensurate with the number of reviewers, as well as their level of expertise and time required to complete the review.	**$500-$4,000 Review**
VISION CARE		
	Capitation or fee-for-service charges for vision care services will be paid as claims and will appear in Employer's monthly check register. Such payments will be at Connecticut General's applicable capitation or fee-for-service charges then in effect, which may be revised from time to time. Some Vision services are provided by Connecticut General and/or designated vendors. The rates and identity of the provider of vision services will be made available upon request.	**All products**
PROVIDER NETWORK AFFILIATION FEES		
	Connecticut General contracts directly or indirectly with other managed care entities and third party network vendors for access to their provider networks and discounts. These third parties charge either a network access fee, which is included in Connecticut General's monthly charges, or a percentage of the savings realized on a claim by claim basis as a result of the application of their discounts. These "network savings fees" are paid from the Bank Account. Additional details regarding specific charges will be provided upon request.	**All products**
OTHER VENDORS AND HEALTH CARE SERVICES PROVIDERS		
	Capitation and fee-for-service charges for various vendors and other providers/arrangers of health care services and/or supplies will be paid as claims for Plan Benefits and will appear in Employer's monthly check register. Such payments will be at Connecticut General's applicable capitation or fee-for-service charges then in effect, which may be revised from time to time. Additional details regarding charges and the identity of the vendor or provider of health care services will be made available upon request.	**All products**

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NOTICE REGARDING PAYMENTS FROM THIRD PARTIES		
	Unless indicated otherwise in the Schedule of Financial Charges, Connecticut General retains all payments it may receive from manufacturers of pharmaceutical products covered under the Plan. Information on the amount of such payments with respect to the Plan will be provided upon request. From time to time, Connecticut General, either directly or through its affiliates, contracts with vendors, provider network managers and providers in connection with various cost containment programs. Connecticut General and its affiliates may receive payments from such parties that are intended to help defray expenses associated with implementing such programs. In addition, Connecticut General and/or its affiliates may receive payments from third parties for the provision of aggregate data, facilitating patient compliance with prescription drug therapy, providing health care services or supplies as subcontractors to other network providers, and other services. Additional details will be provided upon request.	**All products**
ADDITIONAL SERVICES		
Service	**Description**	**Charge**
Well Aware	The CIGNA HealthCare "Well Aware Program for Better Health®". Specific charge information available upon request. Programs include: • Well Aware Asthma Program • Well Aware Low Back Pain • Well Aware Cardiac Program • Well Aware Chronic Obstructive Pulmonary Disease (COPD) Program • Well Aware Diabetes Program	**For OAP: $4.80/employee/month**
Pharmacy Clinical Programs	CIGNA TheraCare Program – a targeted condition drug therapy management program that targets individuals using specialty medications for certain chronic conditions and helps them better understand their condition, medication side effects and importance of adherence.	**Included at No Additional Charge**
Behavioral Health Care Advocacy	Behavioral Health Care Advocacy provides focused utilization review and case management of in-network, outpatient behavioral health services. Specific charge information available upon request.	**Included in Medical Access Fee (Applicable to CA/NC members only)**

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Customer Name: [redacted]
Administrative Services Only Agreement

THIS AGREEMENT, effective October 1, 2010 (the "**Effective Date**") is by and between [redacted] ("**Employer**") and Connecticut General Life Insurance Company ("**Connecticut General**").

RECITALS:

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

WHEREAS, Employer has requested Connecticut General to furnish certain administration services in connection with the Plan 3333822.

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

Section 1. Term and Termination of Agreement

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

i. The date which is at least sixty (60) days from the date that either Party provides written notice to the other party of termination of the Agreement;

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

iii. The date upon which Employer fails to fund the Bank Account as required by this Agreement or fails to pay Connecticut General any charges identified in this Agreement when due provided Connecticut General notifies Employer of its election to terminate;

iv. Any other date mutually agreed upon by the Parties.

Section 2. Claim Administration and Additional Services

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

b. Following (i) termination of this Agreement, except pursuant to Section 1.iii. or (ii) termination of eligibility of a Member, if the required fees have been paid in full, Connecticut General shall process Run-Out Claims for the applicable Run-Out Period (See Schedule of Financial Charges for applicable fees and Run-Out Period). At the termination of any applicable Run-Out Period, Connecticut General shall cease processing Run-Out Claims and make all relevant records in its possession relating to such claims reasonably available to Employer or Employer's designee. Connecticut General is not required to provide proprietary information to Employer or any other party.

c. Employer hereby delegates to Connecticut General the authority, responsibility and discretion to (i) determine eligibility and enrollment for coverage under the Plan according to the information provided by the

Employer, (ii) make factual determinations and to interpret the provisions of the Plan to make coverage determinations on claims for Plan Benefits, (iii) conduct a full and fair review of each claim which has been denied as required by ERISA, (iv) decide level one mandatory appeals of "Urgent Care Claims" (as that term is defined in ERISA), and (v) conduct both mandatory levels of appeal determinations for all "Concurrent", "Pre-service" and "Post-service" claims (as those terms are defined under ERISA) and notify the Member or the Member's authorized representative of its decision. Employer will ensure that all summary plan description materials provided to Members reflect this delegation.

d. In addition to the basic claim administrative duties described above, Connecticut General shall also perform the Plan-related administrative duties agreed upon by the Parties and specified in Exhibit B.

Section 3. Funding and Payment of Claims

a. Employer shall establish a Bank Account, and maintain in the Bank Account an amount sufficient at all times to fund checks written on it for (i) Plan Benefits and (ii) those charges and fees identified in the Schedule of Financial Charges as payable through the Bank Account (collectively "**Bank Account Payments**") (iii) any sales or use taxes, or any similar benefit- or plan-related charge or assessment however denominated, which may be imposed by any governmental authority. Bank Account Payments may include without limitation: (i) capitated (i.e. fixed per Member) payments to Participating Providers; (ii) amounts owed to Connecticut General; (iii) and amounts paid to Connecticut General's affiliates and/or subcontractors for, among other things, network access or in- and out-of network health care services/products provided to Members. Connecticut General may credit the Bank Account with payments due Employer under its or an affiliate's stop loss policy.

b. Connecticut General, as agent for the Employer, shall make Bank Account Payments from the Bank Account in the amount Connecticut General reasonably determines to be proper under the Plan and/or under this Agreement.

c. In the event that sufficient funds are not available in the Bank Account to pay all Bank Account Payments when due, Connecticut General shall cease to process claims for Plan Benefits including Run-Out claims.

d. Connecticut General will promptly adjust any underpayment of Plan Benefits by drawing additional funds due the claimant from the Bank Account. In the event Connecticut General overpays a claim for Plan Benefits or pays Plan Benefits to the wrong party, it shall take all reasonable steps to recover the overpayment; however, Connecticut General shall not be required to initiate court, mediation, arbitration or other administrative proceedings to recover any overpayment. Connecticut General shall not be responsible for reimbursing any unrecovered payments of Plan Benefits unless made as a result of its gross negligence or intentional wrongdoing.

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

This provision shall survive termination of this Agreement

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Section 4. Charges

a. Charges. Connecticut General shall provide to Employer a monthly statement of all charges Employer is obligated to pay under this Agreement that are not paid as Bank Account Payments. Payment of all billed charges shall be due on the first day of the month, as indicated on the monthly statement. Payments received after the last day of the month in which they are due, shall be subject to late payment charges, from the due date at a rate calculated as follows: the one (1) year Treasury constant maturities rate for the first week ending in January plus five percent (5%). For purposes of calculating late payment charges, payments received will be applied first to the oldest outstanding amount due. Connecticut General may reasonably revise the methodology for calculating late payment charges upon thirty (30) days' advance written notice to Employer.

b. Member Changes – Additions and Terminations. If an employee becomes a Member on or before the fifteenth (15th) day of the month, full charges applicable to that Member shall be due for that Member for that month. If coverage does not start or ceases on or before the fifteenth (15th) day of the month for a Member, no charges shall be due for that Member for that month.

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

This provision shall survive termination of this Agreement.

Section 5. Enrollment and Determination of Eligibility

a. Eligibility Determinations and Information. Employer is responsible for administering Plan enrollment. In determining any person's right to benefits under the Plan, Connecticut General shall rely upon enrollment and eligibility information furnished by the Employer. Such information shall identify the effective date of eligibility and the termination date of eligibility and shall be provided promptly to Connecticut General in a form and with such other information as reasonably may be required by Connecticut General for the proper administration of the Plan.

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

c. Reconciliation of Eligibility and Information and Default Terminations. Connecticut General will periodically share potential discrepancies in eligibility information with Employer. Employer will review and reconcile any discrepancies within thirty (30) days of receipt. If Employer fails to timely do so, Connecticut General may

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terminate coverage for any Member not listed as eligible in Employer's submitted eligibility information.

Section 6. Claim Audits and Confidentiality

a. Employer may, in accordance with the following requirements and at no additional charge while this Agreement is in effect, audit Connecticut General's payment of Plan Benefits:

i. Employer shall provide Connecticut General 45 days advance written request for audit. Employer and Connecticut General will agree on an independent, third party auditor to conduct the audit (the "**Auditor**") and the date for the audit during regular business hours at Connecticut General's office(s). Employer shall be responsible for its Auditor's costs. The audit shall be conducted in accordance with the terms of Connecticut General's Claim Audit Agreement attached hereto as Exhibit C, which is hereby agreed to by Employer and which shall be signed by the Auditor prior to the start of the audit.

ii. If Employer has 5,000 or more employee Members, Employer may conduct one such audit every Plan Year (but not within 6 months of a prior audit); otherwise, Employer may conduct one such audit every two Plan Years (but not within 18 months of a prior audit).

iii. Auditor will review payment documents relating to a random, statistically valid sample of 225 claims paid during the two prior Plan years and not previously audited (the "**Audit**") subject to any contrary terms in participating Provider agreements. Connecticut General will reasonably cooperate with audits other than the "Audit" subject to mutually agreed charges. With respect to the audits other than the "Audit", the scope may include types of claims prone to overpayments provided the types of claims prone to underpayments are equally included. With respect to the Audit and any other audit, any claim adjustments will be based upon the actual claims reviewed and not upon statistical projections or extrapolations.

b. Subject to the requirements of applicable law, the terms of this Agreement and the Privacy Addendum in Exhibit D, a signed Business Associate agreement between Employer and designee, and a signed Confidentiality Agreement by applicable designee, Connecticut General shall release copies of confidential claims and Plan Benefit payment information in Connecticut General's claims system ("**Confidential Information**") and may release copies of proprietary information relating to the Plan in Connecticut General's claims system ("**Proprietary Information**") to the Employer and/or its designees. Employer agrees that Employer and its designees will keep Confidential Information and Proprietary Information confidential and will use Confidential Information and Proprietary Information solely for the purpose of administering the Plan or as otherwise required by law. Employer is solely responsible for the consequences of any use, misuse, or disclosure of Confidential Information provided by Connecticut General pursuant to this paragraph b.

c. Connecticut General will maintain the confidentiality of all Protected Health Information in its possession in accordance with the Privacy Addendum in Exhibit D.

d. Upon termination of this Agreement, Connecticut General shall make information available to the extent administratively feasible if the Parties agree upon the charge to be paid by Employer.

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

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Customer Name: [redacted]
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Section 7. Plan Benefit Liability

a. Employer Liability for Plan Benefits. Employer is responsible for all Plan Benefits including any Plan Benefits paid as a result of any legal action. Employer is responsible for reimbursing Connecticut General, its directors, officers and employees for any reasonable expense incurred (including reasonable attorneys fees) by them in the defense of any action or proceeding involving a claim for Plan Benefits. Connecticut General shall reasonably cooperate with Employer in its defense of such actions.

If Connecticut General pays a claim for Extra-Contractual Benefits, Employer is responsible for funding the payment and such payments shall not be considered in determining reimbursements or payments under stop loss insurance or in determining any risk-sharing or performance guarantee reimbursements. Employer shall reimburse Connecticut General for any liability or expenses (including reasonable attorneys fees) it may incur in connection with making such payments.

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

These reimbursement obligations shall survive termination of this Agreement.

Section 8. Modification of Plan and Administrative Duties and Charges

a. Connecticut General shall have the right to revise the charges identified in this Agreement (i) on each anniversary of this Agreement, (ii) at any time by giving Employer at least sixty (60) days' prior written notice, but not more frequently than once in a six (6) month period, (iii) upon any modification or amendment of the benefits under the Plan or Connecticut General's administrative duties, (iv) upon any variation of fifteen percent (15%) or more in the number of Members used by Connecticut General to calculate its charges under the Agreement, and/or (v) upon any change in law or regulation that materially impacts Connecticut General's liabilities and/or responsibilities under this Agreement.

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

c. Modification of Connecticut Generals' duties shall be by mutual agreement. The parties shall reflect such modification and any revised charges (if applicable) in a letter agreement which shall become part of this Agreement.

Section 9. Modification of Agreement

This Agreement constitutes the entire contract between the parties regarding the subject matter herein. Except as otherwise provided herein, the provisions of this Agreement shall control in the event of a conflict with the terms of any other agreements. No modification or amendment hereto shall be valid unless in writing and signed by an authorized person of each of the parties, except that modification of fees pursuant to Section 8 above may be made by written notice to Employer by Connecticut General. If Employer pays such revised fees or fails to object to such revision in writing within fifteen (15) days of receipt, the Agreement shall be deemed modified to reflect the fees as communicated by Connecticut General.

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Section 10. Laws Governing Contract

This Agreement shall be construed in accordance with the laws of the State of Connecticut without regard to conflict of law rules, and both parties consent to the venue and jurisdiction of its courts.

Section 11. Information in Connecticut General's Processing Systems

Connecticut General may retain and use all Plan related claim and Plan Benefit payment information recorded for or otherwise integrated into Connecticut General's business records including claim processing systems during the ordinary course of business (provided, however, that claim or payment information will be available to Employer pursuant to Section 6). Connecticut General will retain claim and payment information as required by applicable law.

Section 12. Resolution of Disputes

Any dispute between the Parties arising from or relating to the performance or interpretation of this Agreement ("**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 12.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 Hartford, Connecticut. 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 Controversy shall be settled exclusively by binding arbitration. The arbitration shall be conducted in the same location as noted in Section 12.b. above, in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration. The arbitration shall be binding on the Parties to the Agreement and on any respective affiliates which joined in the arbitration. The arbitrator's decision shall be final, conclusive and binding, and no action at law or in equity may be instituted by either Party other than to enforce the arbitrator's award. Judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Each Party shall assume its own costs and attorneys fees. The arbitrator's compensation and expenses and any administrative fees or costs associated with the arbitration proceeding shall be borne equally by the Parties.

This provision shall survive termination of this Agreement.

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Section 13. Third Party Beneficiaries

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

Section 14. Waivers

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

Section 15. Headings

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

Section 16. Severability

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

Section 17. Force Majeure

Connecticut General shall not be liable for any failure to meet any of the obligations required under this Agreement where such failure to perform is due to any contingency beyond the reasonable control of Connecticut General, its employees, officers, or directors. Such contingencies include, but are not limited to, acts or omissions of any person or entity not employed or reasonably controlled by Connecticut General, its employees, officers, or directors, acts of God, fires, wars, accidents, labor disputes or shortages, and governmental laws, ordinances, rules or regulations.

Section 18. Assignment and Subcontracting

Neither Party may assign any right, interest, or obligation hereunder without the express written consent of the other Party; provided, however that Connecticut General may assign any right, interest, or responsibility under this Agreement to its affiliates and/or subcontract specific obligations under the Agreement provided that Connecticut General shall not be relieved of its obligations under the Agreement when doing so.

Section 19. Notices

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

To Connecticut General:
Connecticut General Life Insurance Company
8505 East Orchard Road
Greenwood Village, CO 80111
Attention: John Palmieri,
Underwriting Senior Director

To Employer:
[redacted]

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

Section 20. Identifying Information and Internet Usage

Except as necessary in the performance of their duties under this Agreement, neither party may use the other's name, logo, service marks, trademarks or other identifying information or to establish a link to the other's World Wide Web site without its prior written approval.

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Section 21. Definitions

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

Bank Account – a benefit plan account with a bank designated by Connecticut General. Established and maintained by Employer in its or a nominee's name.

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

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

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

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

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

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

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

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

Run-Out Claims – claims for Plan Benefits relating to health care services and products that are incurred prior to termination of this Agreement or termination of a Plan benefit option, as applicable.

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SIGNATURES

IN WITNESS WHEREOF, the parties have caused this Agreement, and all Exhibits and Addenda to this Agreement, to be executed in duplicate and signed by their respective officers duly authorized to do so as of the dates given below. Employer executes as the authorized representative of the Plan with respect to the Privacy Addendum to this Agreement.

Dated at _____, _____

This _____ day of _____, _____

[redacted]

By_____
Name:
Its
Duly Authorized

Dated at Hartford, Connecticut

This 6th day of October, 2010

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

By:_____
Name: Jessica S. Sheriff
Its Contractual Agreement Unit Manager
Duly Authorized

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Exhibit A - Plan Document

ERISA Plan No. 501

A "Summary Plan Document" or "Plan Booklet" that includes Plan Benefits and Members' rights and responsibilities under the Plan will be provided by Employer to Connecticut General and attached hereto. If Employer has not provided Connecticut General with a copy of its finalized Plan Booklet by the time this Agreement is effective, Connecticut General will administer the Plan in accordance with the medical management and claims administration policies and procedures and/or practices then applicable to its own health insurance business and the definitions and other language contained in the draft version of the Plan Booklet provided by Connecticut General to Employer. Connecticut General will continue to administer the Plan in this manner until Connecticut General receives the finalized Plan Booklet and follows its preparation and review process. After that time, Connecticut General will use the finalized Plan Booklet to administer Plan.

ATTORNEYS' EYES ONLY

Customer Name: [redacted]
Administrative Services Only Agreement

Exhibit B – Services

BANKING AND ADMINISTRATION		
All products excluding Health Savings Account		
1.	Furnishing Connecticut General's standard bank account activity data reports to Employer as and when agreed upon. Connecticut General's administration of your plan does not include performing obligations, if any, under state escheat or unclaimed property laws. It is Employer's responsibility to determine the extent to which these laws may apply to the Plan and to comply with such laws.	**All Products**
2.	Reporting to Employer the claim payment information required in connection with Section 6041of the Internal Revenue Code.	**All Products**
3.	If Employer has elected, pursuant to section 63 of the New York Health Care Reform Act of 1996 (section 2807-t of the Public Health Law) ("the Act"), to pay the assessment on covered lives set forth in section 63 and has consented to the conditions set forth in section 63, Connecticut General shall file such forms and pay such assessment on covered lives on behalf of Employer through the Bank Account to the extent set forth in section 63. Such obligation shall end immediately upon Employer's failure to provide any information required by Connecticut General to fulfill this obligation, the failure to comply with any requirement imposed upon Employer pursuant to the Act or the failure of Employer to properly fund the Bank Account. Connecticut General shall file applicable forms and pay assessments/surcharge on covered lives on behalf of Employer in accordance with and as required by other applicable state law and regulations including: Massachusetts Uncompensated Care Trust Fund Maine Dirigo Health Reform Act Louisiana High Risk Health Insurance Association Fund	**All Products excluding Vision PPO**
CLAIM ADMINISTRATION		
All products excluding Health Savings Account		
1.	Calculation of benefits, check preparation and communications through Connecticut General's standard processes.	**All Products**

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ATTORNEYS' EYES ONLY

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2.	Preparation and delivery of Connecticut General's standard claim forms to Employer for issuance to Members.	**All Products**
3.	Investigation of claims, as necessary.	**All Products**
4.	Discussion of claims, where appropriate, with providers of health services.	**All Products**
5.	Performance of internal audits of Plan Benefit payments on a random sample basis.	**All Products**
6.	Application of claim control procedures.	**All Products**
7.	Response to Insurance Department complaints.	**All Products**
8.	Shared toll-free telephone service for Employer calls to Connecticut General Claim office.	**All Products**
9.	Member services and provider relations services.	**All Products**
10.	Explanation of Benefit ("EOB") statements when applicable.	**All Products**
11.	Notification to Members of denied Plan Benefit claims, the reason for the denial and appeal rights.	**All Products**
12.	Eligibility verification using monthly Member eligibility list updated by Employer.	**All Products**
	Medical Only	
1.	Connecticut General's standard enrollment forms are prepared and delivered to Employer for distribution to individuals eligible to enroll in the Plan.	**All Medical Products**
2.	Connecticut General's standard ID card with toll-free telephone number are prepared and mailed directly to Members.	**All Medical Products**
3.	Administration of subrogation/conditional Claim Payment (terms described in Exhibit E).	**All Medical Products**
	Dental Only	
1.	Connecticut General's standard enrollment forms are prepared and delivered to Employer for distribution to individuals eligible to enroll in the Plan.	**All Dental Products**
2.	Standard Dental predetermination of benefits for dental procedures.	**All Dental Products**
3.	The Oral Health Integration Program (OHIP) includes the provision of administrative services necessary to provide eligible members with certain health conditions enhanced dental benefits. OHIP, which currently consists of the Oral Health Maternity, Diabetes and Cardiovascular Programs, is aimed at improving overall health by encouraging members to obtain needed dental treatment by providing enhanced benefits and may be expanded to include new programs in the future.	**All Dental Products**

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ATTORNEYS' EYES ONLY

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Customer Name: [redacted]
Administrative Services Only Agreement

	Pharmacy Only	
1.	Connecticut General's standard ID cards with toll-free telephone number are prepared and delivered to Employer for distribution to Members.	**All Pharmacy Products**
2.	Pharmacy claims are adjudicated typically on-line at time of service without access to information on other coverage, and therefore coordination of benefits (COB) for pharmacy claims does not occur. Claims for Plan Benefits will be paid regardless of coverage under another plan.	**All Pharmacy Products**
3.	Connecticut General's standard drug utilization review services.	**All Pharmacy Products**
4.	Connecticut General will maintain a prescription drug formulary(ies) and possibly other preferred pharmaceutical lists that identify preferred and non-preferred products. In selecting preferred products, Connecticut General attempts to manage to the lowest net cost in the aggregate; however, not every preferred formulary product is the product with the lowest net cost within the applicable therapeutic class for your plan and/or members in your plan. For example, the preferred product may be selected because it is clinically superior, the subject of favorable payment (rebate) arrangements between Connecticut General and the product's manufacturer, is anticipated to become available in a lower-cost generic drug form, or for other reasons.	**All Pharmacy Products**
	DOCUMENT PRODUCTION	
	All products excluding Health Savings Account	
1.	Preparation and delivery of Member benefit booklet drafts.	**All Products**
	UNDERWRITING SERVICES	
	All products excluding Vision PPO and Health Savings Account	
1.	Provision of Connecticut General's standard annual year-end accounting summary of a) the number and amount of paid claims and b) fees paid.	**All Products**
2.	Connecticut General's standard Underwriting services: a) benefit design analysis, b) reserve analysis, c) projected cost analysis, and d) multi-divisional reports and disclosures.	**All Products**
	HIPAA INDIVIDUAL RIGHTS	
	All products excluding Health Savings Account	
	Handling of requests from Members for access to, amendment and accounting of protected health information, and requests for restrictions and alternative communications as required under federal HIPAA law and regulations, as set out in this Agreement and its Exhibits.	**All Products**

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ATTORNEYS' EYES ONLY

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Customer Name: [redacted]
Administrative Services Only Agreement

	COST CONTAINMENT	
1.	Maximum reimbursable charge determinations, application of non-duplication and coordination of benefits rules and coordination with Medicaid.	**All Medical except OAPIN Medical**
	Connecticut General's standard cost containment controls: maximum reimbursable charge determinations of non-Participating Provider charges for Covered Services (e.g., emergency/urgent care) and application of non-duplication and coordination of benefits rules and coordination with Medicaid.	**OAPIN Medical**
2.	Delivery of information, as necessary, regarding standard application of non-duplication or coordination of benefits.	**All Medical and Dental**
3.	Review of medical bills in accordance with Connecticut General's then current Medical Bill Review program.	**All Medical**
4.	Network Savings Program, a national vendor network that provides discounted rates when a Member accesses care through a Network Savings Program contracted provider.	**All Medical and Dental**
5.	Annual reporting of Connecticut General's standard cost containment results upon Employer's request.	**All Medical and Dental**
6.	Pharmacy Vendor Recoveries (when implemented).	**All Medical Products**
	CUSTOMER REPORTING	
1.	Summary reports of medical and pharmacy cost and utilization experience available through CIGNA web site.	**All Medical, Dental and Pharmacy**
2.	Connecticut General's standard pharmacy utilization reports – fifteen (15) pharmacy utilization reports per year.	**Pharmacy Only**
3.	Standard Stop Loss Reporting: Connecticut General will provide its standard reports and information based upon paid claim data only. Connecticut General will not provide information on incurred-but-not reported claims, projected claims, pre-certifications of coverage, case management information or information on a Member's prognosis or course of treatment. Standard Stop Loss Reporting is a basic service for Employers who have purchased stop loss from Connecticut General and is an optional service provided at an additional fee to Employers who have stop loss through another entity. Connecticut General will provide its standard reports and information only after the stop loss carrier and Employer have executed Connecticut General's standard Hold Harmless/Confidentiality Agreement.	**All Medical**
4.	Connecticut General's standard dental reporting package.	**Dental Only**

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ATTORNEYS' EYES ONLY

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Customer Name: [redacted]
Administrative Services Only Agreement

	EXTERNAL REVIEW PROGRAM	
	Voluntary Member appeal to selected external organization.	**All Medical**
	MEDICAL MANAGEMENT SERVICES	
	Connecticut General provides integrated medical management that includes (depending upon the terms of the Plan) the following core services.	
1.	Pre-Admission Certification and Continued Stay Review (PAC/CSR) services to certify coverage of acute and sub-acute inpatient admissions/stays or provides guidance to appropriate alternative settings. Administered in accordance with Connecticut General's then applicable medical management and claims administration policies, practices and procedures.	**All Medical**
2.	Case Management and Retrospective Review of Inpatient Care, a service designed to provide assistance to a Member who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support.	**All Medical**
3.	Assisting providers in developing Long Term Treatment Plans in the management of chronic or catastrophic cases.	**All Medical**
4.	The CIGNA HealthCare Healthy Babies® Program, a no-cost to Member prenatal program that provides education and support for a healthy pregnancy and healthy baby.	**All Medical**
5.	Consumer decision support tools on myCIGNA.com.	**All Medical**
6.	A panel of external medical experts to assess the safety and effectiveness of new medical technologies.	**All Medical**
7.	The CIGNA HealthCare 24-Hour Health Information Line℠, a service that provides 24 hour toll free access to registered nurses and an extensive audio health information library.	**All Medical**
8.	The CIGNA LIFESOURCE Organ Transplant Network®, that gives participants access to quality care at nationally recognized transplant centers for certain types of organ and tissue transplants.	**All Medical**
9.	A Health Education Program that delivers mailings to Members with certain conditions.	**All Medical Except Comprehensive/ Indemnity**
10.	If behavioral health services are provided/arranged by CIGNA Behavioral Health (CBH), CBH provides utilization review and case management for both inpatient and outpatient, in-network behavioral health services.	**OAP Medical Products**
11.	Implementing clinical quality measurements, managing data, tracking and validating performance and initiating continuous quality improvement.	**All Medical Except Comprehensive/ Indemnity**
12.	Transition of care services to allow Members with defined conditions to continue treatment with non-Participating Providers after enrollment for continued uninterrupted care for a limited time.	**All Medical Except Comprehensive/ Indemnity**

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ATTORNEYS' EYES ONLY

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Customer Name: [redacted]
Administrative Services Only Agreement

	NETWORK MANAGEMENT SERVICES	
	Connecticut General, and/or its affiliates shall:	
1.	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, capitation, per diem charges, incentive bonuses, case rates, withholds etc.). The amount and type of negotiated reimbursement may vary depending upon the type of plan. For example, a hospital may accept less for patients enrolled in certain types of plans than others;	**All Medical**
	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, capitation, per diem charges, incentive bonuses, case rates, withholds etc.);	**All Dental**
2.	Credential and re-credential Participating Providers in accordance with Connecticut General's credentialing requirements and ensure that third-party network vendors credential/re-credential Participating providers in accordance with Connecticut General's requirements;	**All Medical and Dental**
3.	Review Participating Provider compliance with protocols and procedures for quality, participant satisfaction, and grievance resolution;	**All Medical and Dental**
4.	Facilitate the identification of Participating Providers by Members; and	**All Medical and Dental**
5.	Maintain Member services staff to respond to Member inquiries.	**All Medical and Dental**
	BEHAVIORAL HEALTH	
	CIGNA Behavioral Health Connecticut General has contracted with an affiliate, CIGNA Behavioral Health ("CBH"), to provide or arrange for the provision of managed in-network behavioral health services, CBH is a participating provider, and is reimbursed primarily on a monthly fixed fee basis. This fixed fee for CBH services will be paid as claims and will appear in your monthly reporting and on financial documents as capitation. Such payments will be at the relevant monthly rates then in effect. The monthly rates paid to CBH vary depending on geographic location of members and on benefit design, and may be subject to change. The rates will be made available upon request.	**OAP Products (Applicable to Non-California and North Carolina members)**

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ATTORNEYS' EYES ONLY

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Customer Name: [redacted]
Administrative Services Only Agreement

	The fixed fee also includes lifestyle management programs and a cognitive behavioral modification program. Behavioral claims from a client specific network are not included in the behavioral monthly fixed fee and will be paid from the Bank Account. In some states, payment for behavioral health services must be paid on a fee-for-service basis. In these states, fee-for-service payments for behavioral health services and the CBH administrative fee (including the lifestyle management programs and a cognitive behavioral modification program) will be paid from the Bank Account as claims and will appear in your monthly reporting.	*(Continued from previous page)*
	CIGNA STAFF MODEL HEALTHPLAN SERVICES	
	Participating Providers in Arizona include the CIGNA HealthCare of Arizona, Inc. staff model ("CIGNA Medical Group"). Members may at some time receive treatment from a CIGNA Medical Group facility or provider even if they do not reside in Arizona (as when traveling). Members utilizing the IPA network will access certain specialty and/or ancillary services (including laboratory and urgent care services) through the CIGNA Medical Group system. Lab services are not provided by CIGNA Medical Group for Members in PPO, PPO Plus or EPO plans. Except as provided below, for services provided to Members CIGNA Medical Group is paid on a fee schedule basis at the rates in effect at the time of service (as may be revised from time to time). A representative CIGNA Medical Group fee schedule of routinely performed services is attached. A copy of the full fee schedule is available on request. If the Plan requires Members to select a primary care physician (PCP), Phoenix area Members who do not select a PCP during open enrollment are assigned to a CIGNA Medical Group PCP. CIGNA Medical Group is paid a monthly primary care capitation amount for those Phoenix area participants who select or are assigned to a CIGNA Medical Group PCP. Charges will appear on the monthly check register at the rates in effect at the time of payment. Primary care capitation charges are age/sex adjusted and may be revised from time to time. A primary care capitation rate grid and a list of the services included in the capitation are available upon request.	**OAP**

Cigna_TML00125199

Customer Name: [redacted]
Administrative Services Only Agreement

CIGNA HEALTHCARE OF ARIZONA - CIGNA MEDICAL GROUP (CMG)
REPRESENTATIVE FEE SCHEDULE OF ROUTINELY PERFORMED MEDICAL SERVICES
EFFECTIVE 06/01/2008

(Applicable to all Open Access Plus accounts)

CPT Service Code	Service Description	Charge
45330	Sigmoidoscopy, flexible; Diagnostic (combined rate, includes facility fee $485.00)	$552.18*
45378	Diagnostic Colonoscopy (combined rate, includes facility fee $650)	$888.35**
71020	Chest X-Ray, Pa & Lat	$36.30
74000	Abdomen X-Ray (Kub)	$29.84
77057	Mammogram, Screening (Bilateral)	$81.73
80053	Comprehensive Metabolic Panel	$21.42
80061	Cardiac Risk	$27.14
82565	Creatinine; Blood	$10.38
82947	Glucose, Serum	$7.95
84075	Phosphatase, Alkaline,Blood	$10.48
84443	Tsh, Assay	$34.03
84450	Sgot (Ast) Transaminase	$10.47
84520	Bun (Urea Nitrogen)Assay	$7.99
85025	CBC and Differential	$13.01
87086	Culture, Urine, Colony Ct	$16.36
88164	Cytopathology, Slides	$21.40
88305	Surg Path, Gross and Micro	$149.44
92014	Eye Exam & Treatment	$95.91
92567	Tympanometry	$21.98
93000	Electrocardiogram, Complete	$26.83
94760	Oximetry Single Determination	$2.31
95115	Allergy Injection, Single	$15.47
95117	Allergy Injection, Multiple	$19.61
99211	Office Visit, Est Min (Md Or Non-Md)	$21.51
99212	Office Visit, Est Prob Focused	$38.57
99213	Office Visit, Est Exp Prob Foc	$52.55
99214	Office Visit, Est Detailed	$82.44
99231	Subsequent Hospital Care	$34.12
99242	Office Consult, Exp Prob Focused, 30 Minutes	$92.04
99395	Well Exam, Est, 18-39 Years	$97.18
99396	Well Exam, Est, 40-64 Years	$107.41

Customer Name: [redacted]
Administrative Services Only Agreement

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

The CMG CareToday (CMG low acuity clinics) visit rate is $59. Lab tests performed at the CMG CareToday facilities are $10 per service. A complete CMG CareToday fee schedule is available on request.

ASC (Ambulatory surgical center) grouper rates based on 2006 Medicare for facility component of outpatient surgery services:

Group 1 - $485
Group 2 - $650
Group 3 - $740
Group 4 - $900
Group 5 - $950
Group 6 - $1100
Group 7 - $1420
Group 8 - $1400
Group 9 - $1200
Unlisted - $740

Cigna Medical Group pharmacy fee schedule:

Brand Name: AWP – 15% + $2.75*** dispensing fee
Generic: If MAC pricing is available then MAC +$2.75***
If no MAC price available then AWP – 15% + $2.75 dispensing fee

Plan charges are reduced by any applicable copayment, coinsurance and/or deductible for service. Services not identified by CPT code or codes without established RVUs are billed at the 50th Percentile of the Arizona Regional Medicode Schedule.

Notes:

* Incorrectly reflected as $798.42 rather than $807.18 in prior CMG Fee Schedule dated 3/1/2007 ($807.18 charge was effective as of 3/1/2007). As of 6/1/2008, charge reduced to $485.00 facility charge and $552.18 total charge.

**Incorrectly reflected as $857.26 rather than $888.35 in prior CMG Fee Schedule dated 3/1/2007 ($888.35 charge was effective as of 3/1/2007). As of 6/1/2008, charge remains $888.35.

***Incorrectly reflected as $2.50 rather than $2.75 in prior CMG Fee Schedule dated 3/1/2007. ($2.75 has been correct charge since inception of OAP product.)

Customer Name: [redacted]
Administrative Services Only Agreement

Exhibit C – Claim Audit Agreement (Sample)

A. WHEREAS, Connecticut General Life Insurance Company ("Connecticut General") desires to cooperate with requests by _____(" A Employer") to permit an audit for the purposes set forth below; and

B. WHEREAS, _____("the Auditor") has been retained by Employer for the purpose of performing an audit ("Audit") of claims administered by Connecticut General.

C. WHEREAS, the Auditor and the Employer recognize Connecticut General'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;

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

1. Audit Specifications

The Auditor will specify to Connecticut General 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

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

3. Access to Information

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

5. Comment on Audit Report

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

6. Confidentiality

The Auditor understands that Connecticut General 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 Connecticut General;

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

7. Restricted Use of the Audit Information

With respect to persons other than the Employer, the Auditor will hold and treat information obtained from Connecticut General 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 Connecticut General executed by an officer of Connecticut General, disclose in any manner whatsoever, the results, conclusions, reports or information of whatever nature which it acquires or prepares in connection with the Audit to any party other than the Employer except as required by applicable law. The Employer and Auditor agree to indemnify and to hold harmless Connecticut General 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 Connecticut General's provision of information to the Auditor. The Employer authorizes Connecticut General 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").

Customer Name: [redacted]
Administrative Services Only Agreement

8. Termination

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

Connecticut General Life Insurance Company

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date: _____

Employer: _____

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date: _____

Auditor: _____

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date: _____

Customer Name: [redacted]
Administrative Services Only Agreement

Exhibit D – Privacy Addendum

("Business Associate Agreement")

I. GENERAL PROVISIONS

Section 1. Effect. As of the Effective Date, the terms and provisions of this Addendum are incorporated in and shall supersede any conflicting or inconsistent terms and provisions of (as applicable) the Administrative Services Only Agreement and/or Flexible Spending Account or Reimbursement Accounts Administrative Services Agreement to which this Addendum 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 Addendum 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. Connecticut General, Employer (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 Addendum to the extent necessary to allow either the Plan or Connecticut General 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. Definitions. Certain capitalized terms used in this Addendum are defined in Article V. Terms used in this Addendum 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 Addendum 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 Addendum to a section in the HIPAA Privacy Rule, HIPAA Security Rule, or HITECH means the section then in effect, as amended.

II. OBLIGATIONS OF CONNECTICUT GENERAL

Section 1. Use and Disclosure of PHI. Connecticut General may use and disclose PHI only if such use or disclosure is permitted or required by the HIPAA Privacy Rule, including the applicable provisions of 45 C.F.R. §164.504(e), is required to satisfy its obligations or is permitted under the Agreement, and/or is permitted or required by law, but shall not otherwise use or disclose any PHI. Connecticut General shall not use or disclose, and shall ensure that its directors, officers and employees do not use or disclose, PHI in any manner that would constitute a violation of the HIPAA Privacy Rule or HITECH if done by the Plan, except that Connecticut General may use and disclose PHI as permitted under the HIPAA Privacy Rule (i) for the proper management and administration of Connecticut General, (ii) to carry out the legal responsibilities of Connecticut General or (iii) to provide Data Aggregation services relating to the health care operations of the Plan if such services are required under the Agreement.

Customer Name: [redacted]
Administrative Services Only Agreement

Section 2. Receiving Remuneration in Exchange for PHI Prohibited. Effective for exchanges occurring on or after the date that is six (6) months after the date of the promulgation of final regulations by the Secretary implementing Section 13405(d) of HITECH, Connecticut General shall not directly or indirectly receive remuneration in exchange for any PHI of an Individual, unless the Plan obtained from the Individual, in accordance with 45 C.F.R. § 164.508, a valid authorization that, in accordance with such section, specifies whether the PHI can be further exchanged for remuneration by the entity receiving PHI of that Individual, unless the purpose of the exchange is:

(A) For public health activities (as described in 45 C.F.R. §164.512(b));

(B) For research (as described in 45 C.F.R. §§164.501 and 164.512(i)) and the price charged reflects the costs of preparation and transmittal of the data for such purpose;

(C) For the treatment of the Individual, subject to any applicable regulation preventing PHI from inappropriate access, use, or disclosure;

(D) The health care operation specifically described in the definition of health care operations in 45 C.F.R. §164.501(6)(iv);

(E) For remuneration provided by the Plan to Connecticut General for activities involving the exchange of PHI that Connecticut General undertakes on behalf of and at the request of the Plan pursuant to the Agreement and this Addendum;

(F) To provide an Individual with a copy of his or her PHI pursuant to 45 C.F.R. §164.524; or

(G) Otherwise determined by regulations of the Secretary to be similarly necessary and appropriate as the exceptions described in subsections (A) through (F), above.

Section 3. Limited Data Set or Minimum Necessary Standard and Determination. Connecticut General shall, to the extent practicable, limit its use, disclosure, or request of Individuals' PHI to the Limited Data Set (as defined in 45 C.F.R. §164.514(e)(2)) or, if needed by Connecticut General, 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 Addendum. Connecticut General shall determine what constitutes the minimum necessary to accomplish the intended purpose of such disclosure. Connecticut General's obligations under this Section 3 shall be subject to modification to comply with future guidance to be issued by the Secretary.

Section 4. Security Standards. As required by HITECH Section 13402(a), Connecticut General shall comply with the administrative, physical, and technical safeguards and standards set out in 45 C.F.R. §164.308, §164.310, and §164.312, and with the policies and procedures and documentation requirements set out in 45 C.F.R. §164.316. On and after the effective date of final regulations issued by the Secretary requiring Connecticut General's compliance with 45 C.F.R. §164.314, Connecticut General shall comply with the organizational requirements set forth at 45 C.F.R. §164.314, to the extent applicable.

Section 5. Protection of Electronic PHI. With respect to Electronic PHI, Connecticut General shall:

(A) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that Connecticut General 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 Connecticut General provides such information agrees to implement reasonable and appropriate safeguards to protect it; and,

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

Section 6. Reporting of Violations. Connecticut General shall report to the Plan any use or disclosure of PHI not provided for by this Addendum of which it becomes aware. Connecticut General agrees to mitigate, to the extent practicable, any harmful effect from a use or disclosure of PHI in violation of this Addendum of which it is aware.

Section 7. Security Breach Notification. Connecticut General will notify the Plan of a Breach without unreasonable delay. 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 Connecticut General 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, Connecticut General is not the agent of the Plan or the Employer (as "agent" is defined under common law). Connecticut General 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, Connecticut General 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). Connecticut General will pay the costs of issuing notices required by law and other remediation and mitigation which, in Connecticut General's discretion, are appropriate and necessary to address the Breach. Connecticut General will not be required to issue notifications that are not mandated by applicable law. Connecticut General 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 8. Disclosures to and Agreements by Third Parties. Connecticut General shall ensure that each agent and subcontractor to whom it provides PHI agrees to the same restrictions and conditions with respect to such PHI that apply to Connecticut General pursuant to this Addendum.

Section 9. Access to PHI. Connecticut General 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 10. Availability of PHI for Amendment. Connecticut General 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 11. Modifications to Individual Rights and Accounting of Disclosures. Connecticut General shall comply with, and shall assist the Plan in complying with, responding to Individuals' requests to restrict the uses and disclosures of their PHI under 45 C.F.R. §164.522. This shall include complying with valid requests to restrict the disclosure of certain PHI in accordance with Section 13405(A) of the HITECH Act. As required by HITECH, Connecticut General shall provide Individuals with access to certain PHI in electronic form. Connecticut General 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. Requests for Privacy Protection. Connecticut General shall handle requests by an Individual for privacy protection for such Individual's PHI pursuant to the requirements of 45 C.F.R. §164.522.

Section 13. Processes and Procedures. In carrying out its duties set forth in Article II, Sections 9 – 12, above, Connecticut General 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 Connecticut General any such requests made directly to the Plan or Plan Sponsor. In addition, Connecticut General will implement the Processes and Procedures relating to disclosure of PHI to Plan Sponsor or designated third parties.

Section 14. Availability of Books and Records. Connecticut General 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 Connecticut General on behalf of the Plan, available to the Secretary for purposes of determining the Plan's compliance with the Privacy Rule.

III. TERMINATION OF AGREEMENT WITH CONNECTICUT GENERAL

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 Connecticut General in the event that Connecticut General materially breaches any obligation of this Addendum 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 Connecticut General 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 Addendum, Connecticut General 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, Connecticut General shall terminate the Agreement, if feasible, at the end of such period. However, if neither termination of the Agreement nor cure are feasible, Business Associate shall report the violation to the Secretary.

Section 2. Use of PHI upon Termination. The parties hereto agree that it is not feasible for Connecticut General to return or destroy PHI at termination of the Agreement; therefore, the protections of this Addendum for PHI shall survive termination of the Agreement, and Connecticut General 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.

IV. OBLIGATION OF THE PLAN

The Plan will not request Connecticut General to use or disclose PHI in any manner that would not be permissible under HIPAA or HITECH if done by the Plan.

V. DEFINITIONS FOR USE IN THIS ADDENDUM

"**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 Connecticut General 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 Connecticut General; any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by Connecticut General 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.

"**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 Connecticut General for the Plan, or used, in whole or in part, by Connecticut General 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 Connecticut General 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.

Customer Name: [redacted]
Administrative Services Only Agreement

Connecticut General Life Insurance Company
Standard Business Associate Processes and Procedures

These Standard Business Associate Processes and Procedures apply to each self-funded group health plan ("Plan") of an entity ("Plan Sponsor") that has entered or will enter into an Administrative Services Only Agreement, Flexible Spending Account or Reimbursement Accounts Administrative Services Agreement and/or Continuation Coverage Services Agreement (collectively, as applicable, the "Administrative Services Agreement") with Connecticut General Life Insurance Company ("Connecticut General"). The Plan and Connecticut General are parties to a Business Associate Agreement/Privacy Addendum. 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 Connecticut General 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, Connecticut General 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 Connecticut General 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 Connecticut General 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. Connecticut General 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 Connecticut General 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 Connecticut General under subparagraph (a) above, the Plan delegates to Connecticut General 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 Connecticut General 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, Connecticut General shall incorporate any such amendments in accordance with 45 C.F.R. §164.526.

Customer Name: [redacted]
Administrative Services Only Agreement

Section 3. Accounting of Disclosures. When an Individual requests an accounting of disclosures of PHI held by Connecticut General directly to the Plan or Plan Sponsor, the Plan shall within five (5) business days of such receipt forward the request to Connecticut General to handle. Connecticut General 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 Privacy Protection. Connecticut General shall handle Individuals' requests made to it for privacy protection for PHI in Connecticut General's possession pursuant to the requirements of 45 C.F.R. §164.522. The Plan shall forward to Connecticut General to handle any such requests the Plan receives from Individuals that affect PHI held by Connecticut General.

Section 5. General Provisions Regarding Requests. Connecticut General 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, Connecticut General 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 Connecticut General's response. Connecticut General 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, Connecticut General 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 Connecticut General's obligations under the Administrative Services Agreement requires Connecticut General to disclose or provide access to PHI to Plan Sponsor or any person under the control of Plan Sponsor (including third parties), Connecticut General shall make such disclosure of or provide such access to PHI only as follows:

(i) Connecticut General 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, Connecticut General 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 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. Such employees or other persons (including third parties) will be identified by the Plan in writing (by name, title, or other appropriate designation) to Connecticut General 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 Connecticut General.

Section 7. Disclosures of PHI to Third Parties. Upon the Plan's written request, Connecticut General 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, Connecticut General may require that the Plan have a business associate agreement (within the meaning of the Privacy Rule) with such Designated Third Party.

Customer Name: [redacted]
Administrative Services Only Agreement

Exhibit E – Conditional Claim/Subrogation Recovery Services

I. Plans Without Connecticut General Stop Loss Coverage

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

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

___ Employer

___ An independent recovery vendor whose name and address follow:

___ Connecticut General and its subcontractor(s)

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

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

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

Name:
Title:
Address:
Telephone:

iii. All amounts reimbursed to Employer's benefit payment account shall be refunded at the gross amount. Connecticut General's and its subcontractors' subrogation administration fee on cases where Connecticut General and its subcontractors' have retained counsel and in cases where no counsel has been retained by Connecticut General and its subcontractors, are both reflected in the Schedule of Financial Charges. For the purposes of such fee calculations, the use of counsel to perform ministerial acts such as filing of appearances or defenses in states which require plaintiffs to name employee benefit plans as party defendants and in similar circumstances shall not constitute the retention of counsel.

Customer Name: [redacted]
Administrative Services Only Agreement

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

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

II. Plans with Connecticut General Stop Loss Coverage

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

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

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

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

EXHIBIT G

Administrative Services Only Agreement

By and Between

[redacted]

"Employer"

And

Cigna Health and Life Insurance Company
"CHLIC"

And

[redacted]

Effective Date: January 1, 2013

THIS AGREEMENT AND ITS TERMS ARE PROPRIETARY AND CANNOT BE DISCLOSED WITHOUT THE PERMISSION OF EACH OF THE PARTIES

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ADDENDUM A 40

Customer Name: [redacted]
Administrative Services Only Agreement

THIS AGREEMENT, effective January 1, 2013 (the "**Effective Date**") is by and between [redacted] ("**Employer**") and Cigna Health and Life Insurance Company ("**CHLIC**") and [redacted]).

RECITALS:

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

WHEREAS, Employer has requested CHLIC and [redacted] to furnish certain administration services in connection with the Plan [redacted]

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

Definitions

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

Applicable Law – means the state, federal and international laws and regulations that apply. Applicable Law includes but is not limited to the Employee Retirement Income Security Act of 1974, as amended and the rules and regulations thereunder ("**ERISA**"), the Health Insurance Portability and Accountability Act of 1996, as amended and the rules and regulations thereunder ("**HIPAA**"), the Foreign Corrupt Practices Act ("**FCPA**") and any other anti-bribery or anti-corruption laws in the countries where the Parties conduct business.

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

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

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

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

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

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

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

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

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

Run-Out Claims – claims for Plan Benefits relating to health care services and products that are incurred prior to termination of this Agreement; termination of a Plan benefit option or eligible Members, as applicable.

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Section 1. Term and Termination of Agreement

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

i. The date which is at least sixty (60) days from the date that either Party provides written notice to the other Party of termination of the Agreement;

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

iii. The date upon which Employer fails to fund the Bank Account as required by this Agreement or fails to pay CHLIC any charges identified in this Agreement when due provided CHLIC notifies Employer of its election to terminate;

iv. Any other date mutually agreed upon by the Parties.

Section 2. Claim Administration and Additional Services

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

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

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

d. In addition to the basic claim administrative duties described above, CHLIC shall also perform the Plan-related administrative duties agreed upon by the Parties and specified in Exhibit B and [redacted] shall provide the services described in Addendum A.

Section 3. Funding and Payment of Claims

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

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

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

c. In the event that sufficient funds are not available in the Bank Account to pay all Bank Account Payments when due, CHLIC shall cease to process claims for Plan Benefits including Run-Out Claims.

d. CHLIC will promptly adjust any underpayment of Plan Benefits by drawing additional funds due the claimant from the Bank Account. In the event CHLIC overpays a claim for Plan Benefits or pays Plan Benefits to the wrong party, it shall take all reasonable steps to recover the overpayment; however, CHLIC shall not be required to initiate court, mediation, arbitration or other administrative proceedings to recover any overpayment. CHLIC shall not be responsible for reimbursing any unrecovered payments of Plan Benefits unless made as a result of its gross negligence or intentional wrongdoing.CHLIC shall only be liable for overpayments to the extent set forth in Section 7c of this Agreement

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

This provision shall survive termination of this Agreement.

Section 4. Charges

a. Charges. CHLIC shall provide to Employer a monthly statement of all charges Employer is obligated to pay under this Agreement that are not paid as Bank Account Payments. Payment of all billed charges shall be due on the first day of the month, as indicated on the monthly statement. Payments received after the last day of the month in which they are due, shall be subject to late payment charges, from the due date at a rate calculated as follows: the one (1) year Treasury constant maturities rate for the first week ending in January plus five percent (5%). For purposes of calculating late payment charges, payments received will be applied first to the oldest outstanding amount due. CHLIC may reasonably revise the methodology for calculating late payment charges upon thirty (30) days' advance written notice to Employer.

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

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

This provision shall survive termination of this Agreement.

Section 5. Enrollment and Determination of Eligibility

a. Eligibility Determinations and Information. Employer is responsible for administering Plan enrollment. In determining any person's right to benefits under the Plan, CHLIC shall rely upon enrollment and eligibility information provided by the Employer. Such information shall identify the effective date of eligibility and the termination date of eligibility and shall be provided promptly to CHLIC in a form and with such other information as reasonably may be required by CHLIC for the proper administration of the Plan.

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

c. Reconciliation of Eligibility and Information and Default Terminations. CHLIC will periodically share potential discrepancies in eligibility information with Employer. Employer will review and reconcile any discrepancies within thirty (30) days of receipt. If Employer fails to timely do so, CHLIC may terminate coverage for any Member not listed as eligible in Employer's submitted eligibility information.

Section 6. Claim Audits and Confidentiality

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

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

ii. If Employer has five thousand (5,000) or more employees who are Members, Employer may conduct one such audit every Plan Year (but not within six (6) months of a prior audit); otherwise, Employer may conduct one such audit every two (2) Plan Years (but not within eighteen (18) months of a prior audit).

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

b. Confidentiality

i. Subject to the requirements of Applicable Law, the terms of this Agreement and the Privacy Addendum in Exhibit D, a signed Business Associate agreement between Employer and designee, and a signed Confidentiality Agreement by applicable designee, CHLIC shall release copies of confidential claims and Plan Benefit payment information in CHLIC's claims system ("**Confidential Information**") and may release copies of proprietary information relating to the Plan in CHLIC's claims system ("**Proprietary Information**") to the Employer and/or its designees. Employer agrees that Employer and its designees will keep Confidential Information and Proprietary Information confidential and will use Confidential Information and Proprietary Information solely for the purpose of administering the Plan or as otherwise required by law. Employer is solely responsible for the consequences of any use, misuse, or disclosure of Confidential Information provided by CHLIC pursuant to this paragraph b.

ii. CHLIC will maintain the confidentiality of all Protected Health Information in its possession in accordance with the Privacy Addendum in Exhibit D 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.

c. Upon termination of this Agreement and subject to the provisions of Section 6.b above, CHLIC shall make information available to the extent administratively feasible if the Parties agree upon the charge to be paid by Employer.

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

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Section 7. Plan Benefit Liability

a. Employer Liability for Plan Benefits. Employer is responsible for all Plan Benefits including any Plan Benefits paid as a result of any legal action. Employer is responsible for reimbursing CHLIC and [redacted] its directors, officers and employees for any reasonable expense incurred (including reasonable attorneys' fees) by them in the defense of any action or proceeding involving a claim for Plan Benefits. CHLIC and [redacted] shall reasonably cooperate with Employer in its defense of such actions.

If CHLIC pays a claim for Extra-Contractual Benefits, Employer is responsible for funding the payment and such payments shall not be considered in determining reimbursements or payments under stop loss insurance or in determining any risk-sharing or performance guarantee reimbursements. Employer shall reimburse CHLIC and [redacted] for any liability or expenses (including reasonable attorneys' fees) CHLIC or [redacted] may incur in connection with making such payments.

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

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

These reimbursement obligations shall survive termination of this Agreement.

Section 8. Modification of Plan and Charges

a. CHLIC shall have the right to revise the charges identified in this Agreement (i) on each anniversary of this Agreement, (ii) at any time by giving Employer at least sixty (60) days' prior written notice, but not more frequently than once in a six (6) month period, (iii) upon any material modification or amendment of the benefits under the Plan, (iv) upon any variation of fifteen percent (15%) or more in the number of Members used by CHLIC to calculate its charges under the Agreement, and/or (v) upon any change in law or regulation that materially impacts CHLIC's liabilities and/or responsibilities under this Agreement. Notwithstanding subsections (i) and (ii) of this section 8(a), but subject at all times to subsections (iii), (iv) and (v) hereof, to the extent the Agreement remains in effect, the Medical Administration Charges and Medical Network Access Fee applicable under this Agreement for the period commencing on the Effective Date through December 31, 2017 shall be as set forth in the Schedule of Financial Charges.

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

Section 9. Modification of Agreement

This Agreement constitutes the entire contract between the Parties regarding the subject matter herein. Except, as otherwise provided herein, the provisions of this Agreement shall control in the event of a conflict with the terms of any other agreements. No modification or amendment hereto shall be valid unless in writing and signed by an authorized person of each of the Parties, except that modification of charges pursuant to Section 8 above may be made by written notice to Employer by CHLIC. If Employer pays such revised charges or fails to object to such revision in writing within fifteen (15) days of receipt, the Agreement shall be deemed modified to reflect the charges as communicated by CHLIC.

Customer Name: [redacted]
Administrative Services Only Agreement

Section 10. Laws Governing Contract

a. This Agreement shall be construed in accordance with the laws of the State of Connecticut without regard to conflict of law rules, and both Parties consent to the venue and jurisdiction of its courts.

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

Section 11. Information in CHLIC's Processing Systems

CHLIC and [redacted] may retain and use all Plan-related claim and Plan Benefit payment information recorded for or otherwise integrated into CHLIC's business records including claim processing systems during the ordinary course of business (provided, however, that claim or payment information will be available to Employer pursuant to Section 6). CHLIC will retain claim and payment information as required by Applicable Law.

Section 12. Resolution of Disputes

Any dispute between the Parties arising from or relating to the performance or interpretation of this Agreement ("**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 12.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 Hartford, Connecticut. 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 Controversy shall be settled exclusively by binding arbitration. The arbitration shall be conducted in the same location as noted in Section 12.b. above, in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration. The arbitration shall be binding on the Parties to the Agreement and on any respective affiliates which joined in the arbitration. The arbitrator's decision shall be final, conclusive and binding, and no action at law or in equity may be instituted by either Party other than to enforce the arbitrator's award. Judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Each Party shall assume its own costs and attorneys' fees. The arbitrator's compensation and expenses and any administrative fees or costs associated with the arbitration proceeding shall be borne equally by the Parties.

This provision shall survive termination of this Agreement.

Section 13. Third Party Beneficiaries

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

Section 14. Waivers

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

ATTORNEYS' EYES ONLY Cigna_TML00123574

Customer Name: [redacted]
Administrative Services Only Agreement

Section 15. Headings

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

Section 16. Severability

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

Section 17. Force Majeure

CHLIC and/or [redacted] shall not be liable for any failure to meet any of the obligations required under this Agreement where such failure to perform is due to any contingency beyond the reasonable control of CHLIC and/or [redacted] their employees, officers, or directors. Such contingencies include, but are not limited to, acts or omissions of any person or entity not employed or reasonably controlled by CHLIC and/or [redacted] their employees, officers, or directors, acts of God, fires, wars, accidents, labor disputes or shortages, and governmental laws, ordinances, rules or regulations.

Section 18. Assignment and Subcontracting

Neither Party may assign any right, interest, or obligation hereunder without the express written consent of the other Party; provided, however that CHLIC and [redacted] may assign any right, interest, or responsibility under this Agreement to its affiliates and/or subcontract specific obligations under the Agreement provided that CHLIC or [redacted] shall not be relieved of its obligations under the Agreement when doing so.

Section 19. Notices

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

To CHLIC:
Cigna Health and Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152
Attention: Jeremy Richard, Underwriting Director

To Employer:
[redacted]

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

Section 20. Identifying Information and Internet Usage

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

Customer Name: [redacted]
Administrative Services Only Agreement

SIGNATURES

IN WITNESS WHEREOF, the Parties have caused this Agreement, and all Exhibits and Addenda to this Agreement, to be executed in duplicate and signed by their respective officers duly authorized to do so as of the dates given below. Employer executes as the authorized representative of the Plan with respect to the Privacy Addendum to this Agreement.

Dated at _____, _____

This _____ day of _____, _____

[redacted]

By: [redacted]
Name:
Its
Duly Authorized

Dated at Hartford, Connecticut

CIGNA HEALTH AND LIFE INSURANCE COMPANY

This 3rd day of June, 2013

By: _____
Name: Jessica S. Sheriff
Its Contractual Agreement Unit Manager
Duly Authorized

ATTORNEYS' EYES ONLY

ATTORNEYS' EYES ONLY

Customer Name: [redacted]
Administrative Services Only Agreement

Schedule of Financial Charges

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

ASO Medical Fees	Fees Effective 1/1/13-12/31/13	Fees Effective 1/1/14-12/31/14	Fees Effective 1/1/15-12/31/15	Fees Effective 1/1/16-12/31/16	Fees Effective 1/1/17-12/31/17
OAP ($250 & $500)					
Administration	$11.27	$13.07	$13.97	$14.52	$15.11
Network Access Fee with Personal Health Solutions(PHS)+	$12.50	$12.50	$12.50	$13.00	$13.52
Personal Health Team w/ Your Health First (YHF)	$10.72	$10.72	$10.72	$11.14	$11.59
Total	**$34.49**	**$36.29**	**$37.19**	**$38.66**	**$40.22**
OAP HDHP					
Administration	$11.27	$13.07	$13.97	$14.52	$15.11
Network Access Fee with Personal Health Solutions(PHS)+	$12.50	$12.50	$12.50	$13.00	$13.52
Personal Health Team w/ Your Health First (YHF)	$10.72	$10.72	$10.72	$11.14	$11.59
Total	**$34.49**	**$36.29**	**$37.19**	**$38.66**	**$40.22**
Indemnity DCMS					
Administration	$16.15	$17.95	$18.85	$19.59	$20.37
UR Fee	$0.90	$0.90	$0.90	$0.94	$0.97
Your Health First(YHF)	$5.57	$5.57	$5.57	$5.79	$6.02
Total	**$22.62**	**$24.42**	**$25.32**	**$26.32**	**$27.36**
Fee Increase		5.6%	2.6%	4.0%	4.0%

Cigna Vision	PEPM
	$0.33 *
Total Fees	$30,959.04

Cigna Incentive Points Program (Cigna Population)	PEPM
	$1.48 *
Total Fees	$67,381.44

* Note: Cigna Vision and Cigna Incentive Points are not subject to the five (5) year Fee Guarantee

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ATTORNEYS' EYES ONLY

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Customer Name: [redacted]
Administrative Services Only Agreement

PHARMACY DISCLOSURES		
	Product	**Charge**
Explanatory Note Regarding "AWP"	Industry Changes to or Replacement of Average Wholesale Price (AWP). Notwithstanding any other provision in this Agreement, including in this Exhibit, in the event of any major change in market conditions affecting the pharmaceutical or pharmacy benefit management market, including, for example, any change in the markup, methodologies, processes or algorithms underlying the published AWP(s), CHLIC may adjust any or all of the charges, rates, discounts, guarantees and/or fees in connection with CHLIC's administration of the Plan's Pharmacy Benefit hereunder, including any that are based on AWP, as it reasonably deems necessary to preserve the economic value or benefit of this Agreement as it existed immediately prior to such change. Additionally, and notwithstanding any other provision in this Agreement, including in this Exhibit, CHLIC may replace AWP as its pharmaceutical pricing benchmark with an alternative benchmark and/or may replace Medi-Span, or other such publication as its source for the AWP or alternative benchmark with a different pricing source, provided that CHLIC adjusts any or all such AWP-Based Charges or such alternative benchmark-based charges as it reasonably deems necessary to preserve the economic value or benefit of this Agreement as it existed immediately prior to such replacement or immediately prior to the event(s) giving rise to such replacement, as the case may be.	
Cigna Home Delivery Pharmacy (a CHLIC affiliated company)	Specialty Drugs dispensed by Cigna Home Delivery Pharmacy charged under the medical benefit.	**The drug's charge under a national specialty drug discount schedule that generates a 12.5% annual average aggregate discount off AWP across Specialty Drug Claims dispensed at Cigna Home Delivery Pharmacy to CHLIC's group-client book of business.**
Cigna Home Delivery Pharmacy (a CHLIC affiliated company)	Cigna Home Delivery Pharmacy's discounts are applied to the manufacturer average wholesale price (AWP) for the dispensed size, (or to the AWP for the manufacturer-packaged quantity closest to the dispensed size, if there is no AWP for the dispensed size).	

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ATTORNEYS' EYES ONLY

Customer Name: [redacted]
Administrative Services Only Agreement

Reimbursement to Cigna Home Delivery Pharmacy (a CHLIC affiliated company)for Replacement Prescriptions	Cigna Home Delivery Pharmacy will be reimbursed through the Bank Account for the price (discounted as per this Schedule) for replacement prescriptions shipped by Cigna Home Delivery Pharmacy which are reported as lost or damaged despite Cigna Home Delivery Pharmacy's shipment to the Participant's correct name and address.	
FEES FOR PROCESSING RUN-OUT CLAIMS		
OAP, Indemnity DCMS (Comprehensive) & Vision Care	Run-Out Period of twelve (12) months	**No Additional Charges for processing Run-Out Claims**
SUBROGATION		
	Subrogation/Conditional Claim Payment. Identification, investigation and recovery of claim payments involving other party liability or where another entity is responsible for payment (including by way of example but not by limitation automobile insurance, homeowner insurance, commercial property insurance, worker's compensation). (This service is only provided with respect to Medical coverage).	**5% of recovery plus litigation costs if Counsel is retained and an appearance is filed on behalf of CHLIC or Employer in any litigation, or a lawsuit is filed on their behalf;** **29% of recovery if no Counsel is retained and in all other instances, including cases where state law requires that employee benefit plans be named as party defendants or involuntary plaintiffs.**

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ATTORNEYS' EYES ONLY

Customer Name: [redacted]
Administrative Services Only Agreement

CHLIC COST CONTAINMENT FEES		
CHLIC, a Cigna company, administers the following programs to contain costs with respect to charges for health care service/supplies that are covered by the Plan. In administering these programs, CHLIC contracts with vendors to perform program related services. Specific vendor fees are available upon request. CHLIC's charge for administering these programs is the percentage (indicated below) of either (1) the "net savings" (i.e. the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings, less the applicable vendor fee which generally ranges from 7-11% of the program savings) or (2) the "gross savings" (i.e. the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings; CHLIC pays the applicable vendor fee) or (3) the "recovery" (i.e. the amount recovered) as applicable. For covered services received from non-Participating Providers, CHLIC may apply discounts available under agreements with third parties or through negotiation of the billed charges. These programs are identified below as the Network Savings Program, Supplemental Network & Medical Bill Review (pre-payment). This is consistent with the claim administration practices applicable to CHLIC's own health care insurance business when these programs are implemented. CHLIC charges the percentage shown for administering these programs. Applying these discounts may result in higher payments than if the maximum reimbursable charge is applied. Whereas application of the maximum reimbursable charge may result in the patient being balance billed for the entire unreimbursed amount, applying these discounts avoids balance billing and substantially reduces the patient's out-of pocket cost.		
MEDICAL COST CONTAINMENT		
1.	Network Savings Program	**29% of net savings**
2.	Supplemental Network	**29% of net savings**
3.	Medical Bill Review – (Pre-payment Cost Containment for Non-contracted claims):	
	Inpatient Hospital Bill Review	
	• Line Item Analysis	**Lesser of 5% of hospital bill or the savings achieved**
	• Professional Fee Negotiation	**29% of net savings**
	Outpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
	Physician/Professional Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
4.	Medical Bill Review – (Pre or Post-payment Cost Containment for Non-contracted and Contracted claims):	
	• Bill Audit	**29% of the savings/recovery achieved plus hospital fees or expenses passed through**

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Customer Name: [redacted]
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	Diagnosis Related Grouping (DRG) Validation/Audits and Recovery. An overpayment audit and recovery program in which CHLIC or its vendors review paid claim data to identify overpayments based on inaccurate DRG coding.	**29% of recovery plus any fees or expenses passed through by the hospital or regulatory agency**
	Inpatient Admission Retrospective Review	**29% of recovery**
	Medical Implant Device Audits	**29% of recovery**
5.	COB Vendor Recoveries [Exclusive of pharmacy programs where claims are adjudicated at time prescription is received.]	**29% of recovery**
6.	Secondary Vendor Recovery Program	**29% of recovery**
7.	Provider Credit Balance Recovery Program	**29% of recovery**
8.	High Cost Specialty Pharmaceutical Audits	**29% of recovery**
9.	Class Action Recoveries	**35% of recovery**
	CARE MANAGEMENT/COST CONTAINMENT PROGRAM FEES	
	CHLIC arranges for third parties to provide care management services to: (i) contain the cost of specified health care services/items overall with respect to all plans insured and/or administered by CHLIC, and/or (ii) improve adherence to evidence based guidelines designed to promote patient safety and efficient patient care.	**Specific vendor fees and care management program services are available upon request.**
	ELIGIBILITY OVERPAYMENT RECOVERY FEES	
	Eligibility Overpayment Recovery Vendor Services. Identification and recovery of funds in situations where the overpayment is due to the late receipt of Member termination information. (This service is only provided with respect to Medical coverage).	**29% of recovery**
	EXTERNAL REVIEW FEES	
	External reviews by a third party may be required on a consultative basis as part of the internal appeal process, or pursuant to a formal external review following exhaustion of the internal review process. The cost of a specific third party review is dependent on the nature and complexity of the issue on appeal. In highly complex, non-routine cases or cases related to new technology or experimental-investigational treatment, as part of the internal appeal process a panel of reviewers may be necessary. Third party review charges will be commensurate with the number of reviewers (usually only one is used), as well as their level of expertise and time required to complete the review.	**$300-$4,000 Review**

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ATTORNEYS' EYES ONLY

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Customer Name: [redacted]
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	VISION CARE	
	Capitation or fee-for-service charges for vision care services will be paid as claims and will appear in Employer's standard Bank Account activity data reports. Such payments will be at CHLIC's applicable capitation or fee-for-service charges then in effect, which may be amended from time to time. Some Vision services are provided by CHLIC and/or designated vendors. The applicable rates to Employer for this product and identity of the provider of vision services will be made available upon request.	**All Vision Products**
	STRATEGIC ALLIANCES	
	CHLIC contracts directly or indirectly with other managed care entities and third party network vendors for access to their provider networks and discounts. These third parties charge either a network access fee, which is included in CHLIC's monthly charges, or a percentage of the savings realized on a claim by claim basis as a result of the application of their discounts. Charges based on percentage of savings are paid from the Bank Account. Additional details regarding specific charges will be provided upon request.	**All Medical Products**
	OTHER VENDORS AND HEALTH CARE SERVICES PROVIDERS	
	Capitation and fee-for-service charges for various vendors and other providers/arrangers of health care services and/or supplies will be paid as claims for Plan Benefits and will appear in Employer's standard Bank Account activity data reports. Such payments will be at CHLIC's applicable capitation or fee-for-service charges then in effect, which may be amended from time to time. Additional details regarding charges and the identity of the vendor or provider of health care services will be made available upon request.	**All Products**
	NOTICE REGARDING PAYMENTS FROM THIRD PARTIES	
	From time to time, CHLIC, either directly or through its affiliates, contracts with vendors, provider network managers and providers in connection with various cost containment programs. CHLIC and its affiliates may receive payments from such parties that are intended to help defray expenses associated with implementing such programs.	**All Products**
	COMPLIANCE ASSISTANCE	
	Upon request by the Employer, CHLIC shall provide the following services to assist Employer in meeting its compliance obligations under section 2715 of the Public Health Service Act as added by the Patient Protection and Affordable Care Act and applicable regulations with respect to the provision of the Summary of Benefits ("SBC), translation notice and glossary. (Applicable to all medical plans including HRA and FSA which are considered "group health plans" subject to the SBC requirements.)	
1.	Preparation of SBC, translation notice. CHLIC will not be responsible for any changes that Employer makes to the SBC.	**No charge**
2.	Provide SBC, translation notices prepared by CHLIC to Employer electronically as well as any updates or material modifications.	**No charge**

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3.	Include in SBC a summary of benefits administered by carve-out vendor if Employer or carve-out vendor provide CHLIC with necessary carve-out benefit information at least 12 weeks prior to the date the SBCs are to be delivered to Employer.	**$500 for each benefit option under the Plan for which carve-out vendor benefits are included in SBC**
ADDITIONAL SERVICES		
Service	**Description**	**Charge**
HIPAA Certificates	Individual HIPAA certificates for Members who leave active coverage.	**$0.15/employee/month Included in Medical Administration Charge**
Medical Management	RelayHealth Online Services	**Included in Medical Access Fee**
Incentive Points	The Incentive Points Program allows employers to reward individuals for taking steps to improve their health. Eligible individuals earn points for active participation in Cigna health improvement programs and activities that focus on prevention, lifestyle and behavior modification and disease management. Employees track their incentive activity online and redeem points for a selection of rewards as applicable. Reward types include: HRA/HSA deposits, healthcare premium reductions (if incentive participation file is sent to employer for administration of reward) in addition to gift cards/merchandise.	**$1.48/employee/month** **Applicable to OAP Product Except: Indemnity DCMS Product and Benefit Options:OAP1,OAP1C, OAP2, OAP2C, HDHP & HDHPC**
Your Health First	A proactive health education and improvement program for those with a chronic condition. The program involves services that span across the Member's health needs. Behavioral coaching principles and evidence based medicine guidelines are utilized to optimize self-management skills and foster sustained health improvements. The program targets a chronic population at high risk for near term and future high cost medical expenses. Members are identified as having a chronic condition through a variety of sources which may include: claims data, referrals, and self-identification. A variety of resources are provided to those with a chronic condition, including access to online tools, personalized support, and targeted materials. The program includes the following components: • Chronic Condition-specific coaching • Pre- and post-discharge calls • Lifestyle management coaching: stress, weight management and tobacco cessation • Treatment decision support and coaching In order to continuously improve the effectiveness of our programs, a small sample of Members may be placed in a comparison group which receives alternative services for a limited period of time.	**For OAP & Indemnity DCMS Products: Included in Medical Access Fee**

ATTORNEYS' EYES ONLY

Cigna_TML00123583

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ATTORNEYS' EYES ONLY

Personal Health Team A	A program that encompasses those who are at risk for a health related condition and those who are experiencing health concerns. This program centers on the use of behavioral coaching and case management principles and uses nurses and health coaches. This solution includes the following components: • Pre and post discharge calls when Cigna is the medical carrier • Inpatient advocacy calls (when permission is obtained from the Member) • Short term and complex case management • Vendor partner referral and integration • Predictive modeling outreach • 24 hr HIL post f/u call outreach • Health Risk Assessment Outreach • Multi-session Health and wellness coaching • Treatment decision support and coaching • Gaps in care outreach and counseling • Single point of contact for continuity in the advocate/Member relationship • Life Style Management Programs Members are identified for participation in the Personal Health Team Program through a variety of sources including but not limited to Clinical algorithms developed and implemented by Cigna, Self-enrollment, Inpatient Admissions, Short-term and/or complex case management (medical).	**For OAP Only: Included in Medical Access Fee**
Behavioral Health	Behavioral Care Advocacy provides behavioral health services in which claims are funded on a fee-for service basis. It includes focused utilization review and case management for inpatient, in-network behavioral health services. (This payment arrangement is with respect to the CA/NC member population only).	**Included in Medical Access Fee**
Ad Hoc Reporting	• 20 hours of Ad Hoc reporting per year will be included in the standard package	**Any Reports above twenty (20) hours will incur a charge of $300.00/hour**

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Additional reporting 2013	In addition to the reporting set forth above and subject at all times to applicable privacy laws, regulations and procedures, the following reports, to the extent such information is reasonably available to CHLIC and CHLIC is permitted to disclose such information, shall be provided within the time frames set forth below, in a form and manner consistent with CHLIC's applicable standard practices and procedures and otherwise as reasonably agreed between CHLIC and Employer. Additional reporting for any period on and after December 31, 2013 shall be on terms mutually agreed between CHLIC and Employer. Reports and information shall be based upon paid claim data only. CHLIC will not provide information on incurred-but-not reported claims, projected claims, pre-certifications of coverage, case management information or information on a Member's prognosis or course of treatment. **Quarterly Reports to be provided thirty (30) days following the last day of the preceding calendar quarter:** • Paid Claims Reports • Paid/Incurred Claims Triangle • Claims by Provider Type • Large Claims Report (greater than $50,000) • Distribution of Charges • COB Report • Subrogation/Third-Party Liability Report • Claims Paid by Location • High Frequency Out-of-Network Providers • Provider Discounts Report • Overpayment Listing • Inpatient Utilization • Major Diagnostic Category (MDC) Utilization Analysis • Network Utilization • Key Plan Utilization Stats (e.g., Days/1000, Visits/1000 by service type) **Quarterly Report(s) to be provided forty five (45) days following the last day of the preceding calendar quarter:** • Member Service Operations Report-Health Coaching **Semi-Annual Report(s) to be provided forty five (45) days following the last day of the preceding period:** • Health Risk Questionnaire **Annual Report(s) to be provided forty five (45) days following the last day of the preceding period:** • Health Risk Outcomes* • Financial Outcomes-Health Coaching Program* • Biometric Screening	**Additional reports to be provided are subject to payment of a mutually agreeable charge**

* Delivery Date shall be forty-five (45) days of vendor receipt of completed claims data (assuming a three (3) month cut off)

ATTORNEYS' EYES ONLY

Cigna_TML00123585

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ATTORNEYS' EYES ONLY

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Customer Name: [redacted]
Administrative Services Only Agreement

Client Fund(s)		
	CHLIC shall establish the following fund(s) to assist the Employer in defraying certain Plan-related expenses. If CHLIC performs a service to be reimbursed by the fund, the fund amount shall be credited during the following settlement. If an external vendor provides the service to be reimbursed by the fund, an invoice from the vendor is required to prior to application of fund amounts by CHLIC. Any fund shall be extinguished upon termination of this Agreement and any fund amount not used prior to termination of this agreement shall only be available to Employer for the purpose of funding the cost of those reimbursable services provided prior to such termination.	
Implementation Fund	CHLIC shall make available to Employer the designated amount to be used by Employer to: defray its non-standard expenses associated with implementing a new Plan or program. Fund Effective Date: January 1, 2013 Fund Will Remain in Effect Until: December 31,2013 Unused amounts **will not** carry over for use in the next calendar year.	**$ 40,000.00 First Year Only**
Communication Fund	CHLIC shall make available to Employer the designated amount to be used by Employer to: defray its non-standard expenses associated with the communication to employees of a new Plan or program. Fund Effective Date: January 1, 2013 Fund Will Remain in Effect Until: December 31,2017 Unused amounts **will not** carry over for use in the next calendar year.	**$100,000.00 per year**
Wellness Fund	For clinical/wellness/behavioral programs offered by CHLIC that are purchased, CHLIC will establish a Wellness/Health Improvement Fund in the amount of $50,000.00. These funds will be used to defray the cost of Clinical Wellness and Behavioral programs, and to reward participation in these programs. Wellness/Health Improvement Funds are a one time credit to be used from 01/01/2013-12/31/2017. Unused funds cannot be rolled over in the next calendar year and CHLIC must pre-approve use of the Wellness/Health Improvement Fund	**$50,000.00 per year**
Audit Fund	CHLIC shall make available to Employer the designated amount to be used by Employer to: defray its expenses associated with a pre-implementation audit or an ongoing audit of CHLIC's performance of the administrative services under this Agreement. Fund Amount: $90,000.00 (Once every three (3) years) Fund Effective Date: January 1, 2015 Fund Will Remain in Effect Until: December 31, 2015	**Included in the Medical Administration Charge**

Cigna_TML00123586

Customer Name: [redacted]
Administrative Services Only Agreement

Exhibit A - Plan Document

A "Summary Plan Document" or "Plan Booklet" that includes Plan Benefits and Members' rights and responsibilities under the Plan will be provided by Employer to CHLIC. If Employer has not provided CHLIC with a copy of its finalized Plan Booklet by the time this Agreement is effective, CHLIC will administer the Plan in accordance with the medical management and claims administration policies and procedures and/or practices then applicable to its own health insurance business and the definitions and other language contained in the draft version of the Plan Booklet provided by CHLIC to Employer. CHLIC will continue to administer the Plan in this manner until CHLIC receives the finalized Plan Booklet and follows its preparation and review process. After that time CHLIC will use the finalized Plan Booklet to administer Plan.

ATTORNEYS' EYES ONLY

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Exhibit B – Services

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

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ATTORNEYS' EYES ONLY

9.	Member Explanation of Benefit ("EOB") statements including, when applicable, notice of denied claims, denial reason(s) and appeal rights.	**All Products**
10.	Verify enrollment and eligibility using Member information submitted by Employer and/or its authorized agent.	**All Products**
	Medical Only	
1.	CHLIC's standard enrollment forms are prepared and delivered to Employer for distribution to individuals eligible to enroll in the Plan.	**All Medical Products**
2.	CHLIC's standard ID card with toll-free telephone number are prepared and mailed directly to Members.	**All Medical Products**
3.	Administration of subrogation/conditional Claim Payment (terms described in Exhibit E).	**All Medical Products**
	Pharmacy Only	
1.	CHLIC may receive and retain payments under contracts with drug manufacturers with respect to utilization covered under the Employer's medical benefit for the manufacturer's specialty drugs, which are drugs that typically are injected or infused and derived from living cells; target an underlying rare, chronic or costly condition; and/or require restricted access and/or close monitoring. If CHLIC enters into any such contracts, it does so on its own behalf, and not as agent of the Employer or the Plan.	**All Pharmacy Products**
	DOCUMENT PRODUCTION	
	Products excluding Health Savings Account	
	Prepare and deliver Member benefit booklet drafts to Employer.	**All Products**
	UNDERWRITING SERVICES	
1.	5500 Schedule C reporting.	**All Products**
2.	5500 Schedule A or Annual Reconciliation Disclosure reporting (when applicable)	**All Products**
3.	CHLIC's standard Underwriting services: a) benefit design analysis-b) projected cost analysis.	**All Products**
	HIPAA INDIVIDUAL RIGHTS	
	Products excluding Health Savings Account	
	Handling of requests from Members for access to, amendment and accounting of protected health information, and requests for restrictions and alternative communications as required under federal HIPAA law and regulations, as set out in this Agreement and its Exhibits.	**All Products**
	COST CONTAINMENT	
1.	Maximum reimbursable charge determinations of non-Participating Provider charges for covered services.	**All Medical Products (with out-of-network benefits)**
2.	CHLIC's standard cost containment controls: Application of non-duplication and coordination of benefits rules and coordination with Medicare.	**All Medical Products**
3.	Delivery of information, as necessary, regarding standard application of non-duplication or coordination of benefits.	**All Medical Products**
4.	Review of medical bills in accordance with CHLIC's then current Medical Bill Review program.	**All Medical Products**
5.	Network Savings Program, a national vendor network that provides discounted rates when a Member accesses care through a Network Savings Program contracted provider.	**All Medical Products**

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6.	Annual reporting of CHLIC's standard cost containment results upon Employer's request.	**All Medical Products**
	CUSTOMER REPORTING	
1.	Summary reports of medical cost and utilization experience available through Cigna web site.	**All Medical Products**
2.	Claim Reporting: CHLIC will provide its standard reports and information based upon paid claim data only. CHLIC will not provide information on incurred-but-not reported claims, projected claims, pre-certifications of coverage, case management information or information on a Member's prognosis or course of treatment. Stop Loss Reporting is an optional service provided at an additional fee to Employers who have stop loss through another entity other than CHLIC. CHLIC will provide its standard reporting only after the stop loss carrier and Employer have executed CHLIC's standard Hold Harmless/Confidentiality Agreement.	**All Medical Products**
3.	Regular Periodic meetings with the Client Manager, Clinical Consultant and the Employer will be scheduled to review claims and utilization report results.	**All Medical Products**
	MEMBER EXTERNAL REVIEW PROGRAM	
	CHLIC contracts with three (3) independent review organizations that meet the Patient Protection and Affordable Care Act (PPACA) external review requirements. Members may voluntarily appeal to a selected external independent review organization. If Employer has chosen not to participate in this program, the Employer may be responsible for making other arrangements to meet the Patient Protection and Affordable Care Act (PPACA) external review requirements.	**All Medical Products**
	MEDICAL MANAGEMENT SERVICES	
	CHLIC provides integrated medical management that includes (depending upon the terms of the Plan) the following core services.	
1.	Pre-Admission Certification and Continued Stay Review (PAC/CSR) services to certify coverage of acute and sub-acute inpatient admissions/stays or provides guidance to appropriate alternative settings. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products**
2.	Case Management and Retrospective Review of Inpatient Care, a service designed to provide assistance to a Member who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support.	**All Medical Products**
3.	Assisting providers with resources and tools to enable them to develop Long Term Treatment Plans in the management of chronic or catastrophic cases.	**All Medical Products**
4.	The Cigna HealthCare Healthy Babies® Program, a no-cost to Member prenatal program that provides education and support for a healthy pregnancy and healthy baby.	**All Medical Products**
5.	HealthCare Cost and Quality tools on myCigna.com	**All Medical Products**
6.	A panel of physicians and other clinicians to assess the safety and effectiveness of new and emerging medical technologies. The panel meets monthly to review and update coverage policies.	**All Medical Products**

ATTORNEYS' EYES ONLY

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7.	The Cigna HealthCare 24-Hour Health Information Line℠, a service that provides 24 hour toll free access to registered nurses and an extensive audio health information library.	**All Medical Products**
8.	Cigna *LifeSOURCE* Transplant Network® contracts with over five-hundred (500) transplant programs at more than one-hundred thirty (130) independent transplant facilities. We provide access to solid organ and bone marrow/stem cell transplantation while improving cost containment and reducing financial risk.	**All Medical Products**
9.	A Health Education Program that delivers mailings to Members with certain conditions.	**All Medical Products Except Comprehensive and Indemnity**
10.	If behavioral health services are provided/arranged by Cigna Behavioral Health (CBH), CBH provides utilization review and case management for inpatient in-network behavioral health services. **(CA/NC Members)**	**OAP Products Only**
11.	If behavioral health services are provided/arranged by Cigna Behavioral Health (CBH), CBH provides utilization review and case management for both inpatient and outpatient, in-network behavioral health services. **(Non CA/NC Members)**	**OAP Products Only**
12.	Implementing clinical quality measurements, managing data, tracking and validating performance and initiating continuous quality improvement.	**All Medical Products Except Comprehensive and Indemnity**
13.	Transition of care services to allow Members with defined conditions to continue treatment with non-Participating Providers after enrollment for continued uninterrupted care for a limited time.	**All Medical Products Except Comprehensive and Indemnity**
14.	Focused utilization management of outpatient procedures and identification of appropriate alternatives. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products with PHS Plus**
15.	The services relating to Personal Health Team and Your Health First in the Schedule of Financial Charges are in addition to the basic services set forth in this Exhibit B	**All Medical Products**
	NETWORK MANAGEMENT SERVICES	
	CHLIC, and/or its affiliates shall:	
1.	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, capitation, per diem charges, incentive bonuses, case rates, withholds etc.). The amount and type of negotiated reimbursement may vary depending upon the type of plan. For example, a hospital may accept less for patients enrolled in certain types of plans than others;	**All Medical Products**
2.	Credential and re-credential Participating Providers in accordance with CHLIC's credentialing requirements and ensure that third-party network vendors credential/re-credential Participating Providers in accordance with CHLIC's requirements;	**All Medical Products**
3.	Review Participating Provider compliance with protocols and procedures for quality, Participant satisfaction, and grievance resolution;	**All Medical Products**
4.	Facilitate the identification of Participating Providers by Members; and	**All Medical Products**

ATTORNEYS' EYES ONLY

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5.	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Medical Products**
	BEHAVIORAL HEALTH	
	CHLIC has contracted with an affiliate, Cigna Behavioral Health ("CBH"), to provide or arrange for the provision of managed in-network behavioral health services, CBH is a Participating Provider, and is reimbursed primarily on a monthly fixed fee basis. This fixed fee for CBH services will be paid as claims and will appear in Employer's monthly reporting and on financial documents as capitation. Such payments will be at the relevant monthly rates then in effect. The monthly rates paid to CBH vary depending on geographic location of Members and on benefit design, and may be subject to change. The rates will be made available upon request. The fixed fee also includes lifestyle management programs and a cognitive behavioral modification program. Behavioral claims from a client specific network are not included in the behavioral monthly fixed fee and will be paid from the Bank Account. In some states, payment for behavioral health services must be paid on a fee-for-service basis. In these states, fee-for-service payments for behavioral health services and the CBH administrative fee (including the lifestyle management programs and a cognitive behavioral modification program) will be paid from the Bank Account as claims and will appear in Employer's monthly reporting.	**These services are included in the following products:** **OAP Products (Non CA/NC Members)**
	CIGNA STAFF MODEL HEALTHPLAN SERVICES	
	The Cigna HealthCare of Arizona, Inc. staff model ("Cigna Medical Group") is a Participating Provider located in metropolitan Phoenix, Arizona. Plan Participants may at some time receive treatment from a Cigna Medical Group ("CMG") facility or provider even if they do not reside in Arizona (as when traveling). Participants utilizing the IPA network will access certain specialty and/or ancillary services (including laboratory and urgent care services) through the CMG system. Lab services are not provided by CMG for Participants in PPO or EPO plans. Except as provided below, for services provided to Participants, CMG is paid at the rates in effect at the time of service (as may be revised from time to time). Representative rates for routinely performed services are attached. A complete copy of the rates is available on request under a mutually agreed Non Disclosure Agreement ("NDA"). If the Plan requires Participants to select a primary care physician (PCP), Phoenix area Participants who do not select a PCP during open enrollment are assigned to a CMG PCP. CMG is paid a monthly primary care capitation amount for those Phoenix area Participants who select or are assigned to a CMG PCP. Charges will appear in Employer's standard Bank Account activity data reports at the rates in effect at the time of payment. Primary care capitation charges are age/sex adjusted and may be revised from time to time. A primary care capitation rate grid and a list of the services included in the capitation are available upon request under a mutually agreed Non Disclosure Agreement ("NDA"). Primary care services rendered to Participants in Open Access Plans that do not provide for PCP assignment are paid at the rates then in effect, as described above.	**All Medical Products**

ATTORNEYS' EYES ONLY

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Customer Name: [redacted]
Administrative Services Only Agreement

CIGNA HEALTHCARE OF ARIZONA - CIGNA MEDICAL GROUP (CMG)
REPRESENTATIVE RATES FOR ROUTINELY PERFORMED MEDICAL SERVICES EFFECTIVE OCTOBER 1, 2012

(Applicable to all Open Access Plus Products)

CPT Service Code	Service Description	Rates
45330	Sigmoidoscopy, flexible; Diagnostic (combined rate, includes facility fee $485.00)	$557.97
45378	Diagnostic Colonoscopy (combined rate, includes facility fee $650)	$907.75
71020	Chest X-Ray, Pa & Lat	$30.38
74000	Abdomen X-Ray (Kub)	$24.57
80053	Comprehensive Metabolic Panel	$14.87
80061	Cardiac Risk	$18.85
82565	Creatinine; Blood	$7.22
82947	Glucose, Serum	$5.52
84075	Phosphatase, Alkaline,Blood	$7.28
84443	Tsh, Assay	$23.64
84450	Sgot (Ast) Transaminase	$7.28
84520	Bun (Urea Nitrogen)Assay	$5.56
85025	CBC and Differential	$9.03
87086	Culture, Urine, Colony Ct	$11.36
88164	Cytopathology, Slides	$14.87
88305	Surg Path, Gross and Micro	$104.59
92014	Eye Exam & Treatment	$109.35
92567	Tympanometry	$15.62
93000	Electrocardiogram, Complete	$21.86
94760	Oximetry Single Determination	$2.47
95115	Allergy Injection, Single	$9.69
95117	Allergy Injection, Multiple	$11.85
99211	Office Visit, Est Min (Md Or Non-Md)	$19.21
99212	Office Visit, Est Prob Focused	$39.18
99213	Office Visit, Est Exp Prob Foc	$65.80
99214	Office Visit, Est Detailed	$98.58
99231	Subsequent Hospital Care	$38.26
99242	Office Consult, Exp Prob Focused, 30 Minutes	$92.15
99395	Well Exam, Est, 18-39 Years	$94.20
99396	Well Exam, Est, 40-64 Years	$102.94
G0202	Mammogram, Screening (Bilateral) Digital	$129.54
77052	Add on for iCad	$11.48

Customer Name: [redacted]
Administrative Services Only Agreement

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

The CMG CareToday (CMG low acuity clinics) visit rate is $59. Lab tests performed at the CMG CareToday facilities are $10 per service. A complete list of rates for CMG CareToday services is available on request.

ASC (Ambulatory surgical center) grouper rates based on 2006 Medicare for facility component of outpatient surgery services:

Group 1 - $485
Group 2 - $650
Group 3 - $740
Group 4 - $900
Group 5 - $950
Group 6 - $1100
Group 7 - $1420
Group 8 - $1400
Group 9 - $1200
Unlisted - $740

CMG pharmacy rates:

Brand Name: AWP – 10.56% + $2.75 dispensing fee
Generic: If MAC pricing is available then MAC +$2.75
If no MAC price available then AWP – 15% + $2.75 dispensing fee

Plan charges are reduced by any applicable copayment, coinsurance and/or deductible for service. Services not identified by CPT code or codes without established RVUs are reimbursed at the 50th Percentile of the Arizona Regional Medicode Schedule.

Customer Name: [redacted]
Administrative Services Only Agreement

Exhibit C – Claim Audit Agreement (Sample)

A. WHEREAS, Cigna Health and Life Insurance Company ("CHLIC") desires to cooperate with requests by _____(" Employer") to permit an audit for the purposes set forth below; and

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

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

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

1. Audit Specifications

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

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

2. Review of Specifications

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

3. Access to Information

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

4. Audit Report

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

5. Comment on Audit Report

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

Customer Name: [redacted]
Administrative Services Only Agreement

6. Confidentiality

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

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

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

7. Restricted Use of the Audit Information

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

8. Termination

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

ATTORNEYS' EYES ONLY Cigna_TML00123596

Customer Name: [redacted]
Administrative Services Only Agreement

Cigna Health and Life Insurance Company

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date: _____

Employer: _____

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date: _____

Auditor: _____

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date: _____

Customer Name: [redacted]
Administrative Services Only Agreement

Exhibit D – Privacy Addendum

("Business Associate Agreement")

I. GENERAL PROVISIONS

Section 1. Effect. As of the Effective Date, the terms and provisions of this Addendum are incorporated in and shall supersede any conflicting or inconsistent terms and provisions of (as applicable) the Administrative Services Only Agreement and/or Flexible Spending Account or Reimbursement Accounts Administrative Services Agreement to which this Addendum 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 Addendum 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. CHLIC, Employer (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 Addendum to the extent necessary to allow either the Plan or CHLIC 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. Definitions. Certain capitalized terms used in this Addendum are defined in Article V. Terms used in this Addendum 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 Addendum 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 Addendum to a section in the HIPAA Privacy Rule, HIPAA Security Rule, or HITECH means the section then in effect, as amended.

II. OBLIGATIONS OF CHLIC

Section 1. Use and Disclosure of PHI. CHLIC may use and disclose PHI only if such use or disclosure is permitted or required by the HIPAA Privacy Rule, including the applicable provisions of 45 C.F.R. §164.504(e), is required to satisfy its obligations or is permitted under the Agreement, and/or is permitted or required by law, but shall not otherwise use or disclose any PHI. CHLIC shall not use or disclose, and shall ensure that its directors, officers and employees do not use or disclose, PHI in any manner that would constitute a violation of the HIPAA Privacy Rule or HITECH if done by the Plan, except that CHLIC may use and disclose PHI as permitted under the HIPAA Privacy Rule (i) for the proper management and administration of CHLIC, (ii) to carry out the legal responsibilities of CHLIC or (iii) to provide Data Aggregation services relating to the health care operations of the Plan if such services are required under the Agreement.

Section 2. Receiving Remuneration in Exchange for PHI Prohibited. Effective for exchanges occurring on or after the date that is six (6) months after the date of the promulgation of final regulations by the Secretary implementing Section 13405(d) of HITECH, CHLIC shall not directly or indirectly receive remuneration in exchange for any PHI of an Individual, unless the Plan obtained from the Individual, in accordance with 45 C.F.R. §164.508, a valid authorization that, in accordance with such section, specifies whether the PHI can be further exchanged for remuneration by the entity receiving PHI of that Individual, unless the purpose of the exchange is:

(A) For public health activities (as described in 45 C.F.R. §164.512(b));

(B) For research (as described in 45 C.F.R. §§164.501 and 164.512(i)) and the price charged reflects the costs of preparation and transmittal of the data for such purpose;

(C) For the treatment of the Individual, subject to any applicable regulation preventing PHI from inappropriate access, use, or disclosure;

(D) The health care operation specifically described in the definition of health care operations in 45 C.F.R. §164.501(6)(iv);

(E) For remuneration provided by the Plan to CHLIC for activities involving the exchange of PHI that CHLIC undertakes on behalf of and at the request of the Plan pursuant to the Agreement and this Addendum;

(F) To provide an Individual with a copy of his or her PHI pursuant to 45 C.F.R. §164.524; or

(G) Otherwise determined by regulations of the Secretary to be similarly necessary and appropriate as the exceptions described in subsections (A) through (F), above.

Section 3. Limited Data Set or Minimum Necessary Standard and Determination. CHLIC shall, to the extent practicable, limit its use, disclosure, or request of Individuals' PHI to the Limited Data Set (as defined in 45 C.F.R. §164.514(e)(2)) or, if needed by CHLIC, 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 Addendum. CHLIC shall determine what constitutes the minimum necessary to accomplish the intended purpose of such disclosure. CHLIC's obligations under this Section 3 shall be subject to modification to comply with future guidance to be issued by the Secretary.

Section 4. Security Standards. As required by HITECH Section 13401(a), CHLIC shall comply with the administrative, physical, and technical safeguards and standards set out in 45 C.F.R. §164.308, §164.310, and §164.312, and with the policies and procedures and documentation requirements set out in 45 C.F.R. §164.316. On and after the effective date of final regulations issued by the Secretary requiring CHLIC's compliance with 45 C.F.R. §164.314, CHLIC shall comply with the organizational requirements set forth at 45 C.F.R. §164.314, to the extent applicable.

Section 5. Protection of Electronic PHI. With respect to Electronic PHI, CHLIC shall:

(A) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that CHLIC 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 CHLIC provides such information agrees to implement reasonable and appropriate safeguards to protect it; and,

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

Section 6. Reporting of Violations. CHLIC shall report to the Plan any use or disclosure of PHI not provided for by this Addendum of which it becomes aware. CHLIC agrees to mitigate, to the extent practicable, any harmful effect from a use or disclosure of PHI in violation of this Addendum of which it is aware.

Section 7. Security Breach Notification. CHLIC will notify the Plan of a Breach without unreasonable delay. 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 CHLIC 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, CHLIC is not the agent of the Plan or the Employer (as "agent" is defined under common law). CHLIC 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, CHLIC 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). CHLIC will pay the costs of issuing notices required by law and other remediation and mitigation which, in CHLIC's discretion, are appropriate and necessary to address the Breach. CHLIC will not be required to issue notifications that are not mandated by Applicable Law. CHLIC 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 8. Disclosures to and Agreements by Third Parties. CHLIC shall ensure that each agent and subcontractor to whom it provides PHI agrees to the same restrictions and conditions with respect to such PHI that apply to CHLIC pursuant to this Addendum.

Section 9. Access to PHI. CHLIC 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 10. Availability of PHI for Amendment. CHLIC 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 11. Modifications to Individual Rights and Accounting of Disclosures. CHLIC shall comply with, and shall assist the Plan in complying with, responding to Individuals' requests to restrict the uses and disclosures of their PHI under 45 C.F.R. §164.522. This shall include complying with valid requests to restrict the disclosure of certain PHI in accordance with Section 13405(A) of the HITECH Act. As required by HITECH, CHLIC shall provide Individuals with access to certain PHI in electronic form. CHLIC 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. Requests for Privacy Protection. CHLIC shall handle requests by an Individual for privacy protection for such Individual's PHI pursuant to the requirements of 45 C.F.R. §164.522.

Section 13. Processes and Procedures. In carrying out its duties set forth in Article II, Sections 9 – 12, above, CHLIC 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 CHLIC any such requests made directly to the Plan or Plan Sponsor. In addition, CHLIC will implement the Processes and Procedures relating to disclosure of PHI to Plan Sponsor or designated third parties.

Section 14. Availability of Books and Records. CHLIC 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 CHLIC on behalf of the Plan, available to the Secretary for purposes of determining the Plan's compliance with the Privacy Rule.

III. TERMINATION OF AGREEMENT WITH CHLIC

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 CHLIC in the event that CHLIC materially breaches any obligation of this Addendum 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 CHLIC 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 Addendum, CHLIC 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, CHLIC shall terminate the Agreement, if feasible, at the end of such period.

Section 2. Use of PHI upon Termination. The parties hereto agree that it is not feasible for CHLIC to return or destroy PHI at termination of the Agreement; therefore, the protections of this Addendum for PHI shall survive termination of the Agreement, and CHLIC 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.

IV. OBLIGATION OF THE PLAN

The Plan will not request CHLIC to use or disclose PHI in any manner that would not be permissible under HIPAA or HITECH if done by the Plan.

V. DEFINITIONS FOR USE IN THIS ADDENDUM

"**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 CHLIC 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 CHLIC; any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by CHLIC 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.

"**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 CHLIC for the Plan, or used, in whole or in part, by CHLIC 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 CHLIC pursuant to the requirements of Applicable Law.

Customer Name: [redacted]
Administrative Services Only Agreement

"**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 45 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.

Customer Name: [redacted]
Administrative Services Only Agreement

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 health plan ("Plan") of an entity ("Plan Sponsor") that has entered or will enter into an Administrative Services Only Agreement, Flexible Spending Account or Reimbursement Accounts Administrative Services Agreement and/or Continuation Coverage Services Agreement (collectively, as applicable, the "Administrative Services Agreement") with CHLIC Life Insurance Company ("CHLIC"). The Plan and CHLIC are parties to a Business Associate Agreement/Privacy Addendum. 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 CHLIC 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, CHLIC 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 CHLIC 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 CHLIC 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. CHLIC 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 CHLIC 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 CHLIC under subparagraph (a) above, the Plan delegates to CHLIC 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 CHLIC 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, CHLIC 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 CHLIC directly to the Plan or Plan Sponsor, the Plan shall within five (5) business days of such receipt forward the request to CHLIC to handle. CHLIC 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 Privacy Protection. CHLIC shall handle Individuals' requests made to it for privacy protection for PHI in CHLIC's possession pursuant to the requirements of 45 C.F.R. §164.522. The Plan shall forward to CHLIC to handle any such requests the Plan receives from Individuals that affect PHI held by CHLIC.

ATTORNEYS' EYES ONLY Cigna_TML00123603

Customer Name: [redacted]
Administrative Services Only Agreement

Section 5. General Provisions Regarding Requests. CHLIC 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, CHLIC 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 CHLIC's response. CHLIC 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, CHLIC 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 CHLIC's obligations under the Administrative Services Agreement requires CHLIC to disclose or provide access to PHI to Plan Sponsor or any person under the control of Plan Sponsor (including third parties), CHLIC shall make such disclosure of or provide such access to PHI only as follows:

(i) CHLIC 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, CHLIC 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 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. Such employees or other persons (including third parties) will be identified by the Plan in writing (by name, title, or other appropriate designation) to CHLIC 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 CHLIC.

Section 7. Disclosures of PHI to Third Parties. Upon the Plan's written request, CHLIC 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, CHLIC may require that the Plan have a business associate agreement (within the meaning of the Privacy Rule) with such Designated Third Party.

Customer Name: [redacted]
Administrative Services Only Agreement

Exhibit E – Conditional Claim/Subrogation Recovery Services

I. Plans Without CHLIC Stop Loss Coverage

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

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

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

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

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

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

Name:
Title:
Address:
Telephone:

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

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

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

II. Plans with CHLIC Stop Loss Coverage

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

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

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

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

ATTORNEYS' EYES ONLY Cigna_TML00123605

Customer Name: [redacted]
Administrative Services Only Agreement

ADDENDUM A

TO
ADMINISTRATIVE SERVICES AGREEMENT
BETWEEN

[redacted] **AND**
CIGNA HEALTH AND LIFE INSURANCE COMPANY

AND

EMPLOYER: [redacted]

PART A
BASIC SERVICES PROVIDED BY
[redacted]

I. BASIC SERVICES

A. PROVIDER NETWORK

(i) [redacted] shall make available a network of providers in Massachusetts and Rhode Island ("Provider Network") consisting of providers under contract, either directly with [redacted] or through Intermediaries ("Network Providers"), to deliver Plan services to Participants. Network Providers shall be compensated for Health Care Costs (as defined below) at rates set forth in contracts governing the provision of Plan services. Employer acknowledges that [redacted] negotiates contracts with Network Providers and Intermediaries ("Provider Agreements"), and that the continued participation of any particular Network Provider is based upon many factors, including but not limited to the ability of [redacted] and the Network Provider or Intermediary to reach mutual agreement on contract renewal terms, Network Provider's continuing satisfaction of applicable credentialing standards, and personal decisions such as a Network Provider's retirement or decision to move out of the service area. Network Providers may also, at any time, limit member access to their practice based upon lawful criteria and close or open their panels.

(ii) [redacted] and/or Network Providers may be unable to provide services due to circumstances beyond their control, including but not limited to a major disaster, epidemic, strike, war, terrorist act, civil insurrection, the complete or partial destruction of facilities, riot, or natural disaster. In such case, [redacted] will make a good faith effort to provide administrative services according to this Addendum, and to arrange for the provision of Plan services to Participants to the extent practical and according to Tufts HP's best judgment. [redacted] will incur no liability or obligation for delay or failure to meet its obligations if the failure or delay is caused by such an event.

(iii) [redacted] does not provide health care services; rather, [redacted] arranges for health care through contracts with Intermediaries and Network Providers for Network Providers to provide health care services. Neither Intermediaries nor Network Providers are the employees, agents or representatives of [redacted] for any purposes and [redacted] is not responsible for their acts, omissions, representations or other conduct.

ATTORNEYS' EYES ONLY Cigna_TML00123606

Customer Name: [redacted]
Administrative Services Only Agreement

B. Health Care Costs

Health Care Costs paid to Network Providers consist of payments:

(i) made to providers, Participants, and Intermediaries (defined as organizations of providers, provider networks, and vendors);

(ii) which may be in the form of any of the following: (i) fee for service payments; (ii) capitation payments for designated services, provided, however, Employer acknowledges that prepayment of capitations to providers or Intermediaries for designated services does not relieve Employer's funding obligations for those designated services in the event Participants receive those services from providers not participating in the capitation arrangement or in the event of nonperformance by capitated providers or Intermediaries due to insolvency or otherwise; (iii) payments based upon risk sharing compensation methodologies including but not limited to DRGs, case rates, and withholds and settlements based upon achievement of aggregate performance targets; and (iv) flat fees or contingent payments based upon, for example, percentage of savings; and

(iii) which are for or related to Plan services, including but not limited to (a) claims for Plan services; (b) payments for health care cost management services provided, such as specialty case management programs; and (c) payments related to provider participation in the Provider Network, such as network access fees to Intermediaries;

C. Claim Re-pricing Services and Network Savings Fee

In connection with making available to Plan participants access to its Network Providers in Massachusetts and Rhode Island, [redacted] shall receive a fee for re-pricing claims from its Network Providers to reflect the appropriate rate of reimbursement under the terms of the [redacted] Provider Agreements. [redacted] shall receive either a per claim network savings fee for each re-priced claim or a per employee per month network access fee for each covered employee of Employer residing in Massachusetts and Rhode Island.

ATTORNEYS' EYES ONLY Cigna_TML00123607

Customer Name: [redacted]
Administrative Services Only Agreement

PART B
BUSINESS ASSOCIATE ADDENDUM

1. Definitions. Terms used, but not otherwise defined, in this Part B shall have the same meaning as those terms in the Standards for Privacy of Individually Identifiable Health Information 45 C.F.R. §§ 160 and 164 ("Privacy Regulation"). Covered Entity shall mean the group health plan administered by Employer pursuant to this Agreement.

2. [redacted] agrees to:

   (a) not use or disclose Protected Health Information other than (i) as permitted or required by this Agreement; or (ii) as Required by Law;

   (b) use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement; and to mitigate, to the extent practicable, any harmful effect that is known to [redacted] of a use or disclosure of Protected Health Information by [redacted] in violation of the requirements of this Agreement;

   (c) to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which Tufts HP becomes aware;

   (d) ensure that any agent or subcontractor to whom it provides Protected Health Information received from, or created or received by [redacted] on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to [redacted] with respect to such information;

   (e) provide individuals with: (i) access as required under 45 C.F.R. § 164.524 to any Protected Health Information that is solely in [redacted] possession, for so long as the Protected Health Information is maintained; (ii) amendments to Protected Health Information in a Designated Record Set at the request of the Individual pursuant to 45 C.F.R. § 164.526; and (iii) an accounting of disclosures in accordance with 45 C.F.R. § 164.528; within the time required by Applicable Law following the Individual's request for access, amendment and/or accounting.

   (f) make its internal practices, books and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by [redacted] on behalf of, Covered Entity available to the Secretary of Health and Human Services within a reasonable amount of time following the request, for the purposes of the Secretary determining Covered Entity's compliance with the Privacy Regulations. This provision shall survive termination of this Contract; and

   (g) document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 64.528.

3. Permitted Uses And Disclosures: Except as otherwise limited by this Agreement, [redacted] may:

   (a) use or disclose Protected Health Information on behalf of, or to provide services to, Covered Entity in order to perform the services described in this Contract, if such use or disclosure of Protected Health Information would not violate the Privacy Rule if done by Covered Entity;

   (b) use the Protected Health Information for the proper management and administration of [redacted] and to carry out the present and/or future legal and/or contractual responsibilities of [redacted]

   (c) disclose the Protected Health Information to third parties for the proper management and administration of [redacted] provided that the disclosures are Required By Law, or [redacted] obtains reasonable assurances from the third party 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 was disclosed to the third party, and the third party notifies [redacted] of any instances of which it is aware in which the confidentiality of the information has been breached;

(d) may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. § 164.502(j)(1); and

(e) disclose Protected Health Information to Plan Sponsor for Plan Administration Purposes; and upon the direction of the Covered Entity, [redacted] may disclose the Protected Health Information in its possession to Business Associates of the Covered Entity.

4. Covered Entity Agrees to:

(a) notify [redacted] of any limitation(s) in its notice of privacy practices in accordance with 45 C.F.R. § 164.520, prior to distributing such notice, to the extent that such limitation may affect [redacted] use or disclosure of Protected Health Information. [redacted] shall promptly notify Covered Entity if it cannot comply with the proposed limitation. If [redacted] so notifies Covered Entity, both parties agree to make good faith efforts to develop a mutually agreeable limitation.

(b) notify [redacted] of any changes in, or revocation of, authorization by an Individual to use of disclose Protected Health Information, to the extent that such changes may affect [redacted] use or disclosure of Protected Health Information.

(c) notify [redacted] of any restrictions to the use or disclosure of Protected Health Information that Covered Entity has been requested to agree to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect [redacted] use or disclosure of Protected Health Information. [redacted] shall promptly notify Covered Entity if it cannot comply with the proposed restriction. If [redacted] so notifies Covered Entity, Covered Entity shall not agree to such restriction.

(d) not to request, and shall prohibit Plan Sponsor from requesting, [redacted] to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Regulation if done by Covered Entity, except for uses and disclosures of Protected Health Information for data aggregation or management and administrative activities of [redacted]

(e) and hereby represents and warrants that the Plan Sponsor whom [redacted] has been directed to release Protected Health Information has amended Plan Documents and provided Covered Entity with certification pursuant to 45 C.F.R. § 164.504(f)(2). Covered Entity further represents and warrants that Covered Entity and Plan Sponsor will use PHI solely for legitimate plan administration purposes and will not use PHI for any decisions affecting an employee's employment status.

5. Termination for Cause. Upon either party's knowledge of a material breach of the Agreement by the other, the non-breaching party shall either: (1) notify the breaching party of the breach; in the event that the breach is not cured within thirty (30) calendar days after written notice describing the breach is received by the breaching party, either party may terminate the Agreement; or (2) immediately terminate this Contract if cure is not possible. If neither termination nor cure are feasible, the parties shall report the violation to the Secretary of the Department of Health and Human Services.

Customer Name: [redacted]
Administrative Services Only Agreement

6. Effect of Termination. Upon termination of this Agreement for any reason,

(a) [redacted] shall, if feasible, at [redacted] option, either return or destroy Protected Health Information received from Covered Entity, or created or received by [redacted] on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of [redacted] [redacted] shall retain no copies of the returned or destroyed Protected Health Information.

(b) Covered Entity acknowledges that it will not be feasible for [redacted] to return or destroy all Protected Health Information. [redacted] hereby notifies Covered Entity that it is not feasible to return or destroy any and all documentation required to be maintained by Applicable Law or regulation and/or [redacted]s internal policies and procedures.

(c) [redacted] agrees to notify Covered Entity of any other conditions that make return or destruction infeasible.

(d) [redacted] shall extend the protections of this Agreement to any Protected Health Information not returned or destroyed and agrees to limit further uses and disclosures of such Protected Health Information to those purposes that make return or destruction infeasible, for so long as [redacted] maintains such Protected Health Information. This provision shall survive termination of this Agreement.

[redacted]

By: _____

Name: _____

Title: _____

Date: _____

ATTORNEYS' EYES ONLY Cigna_TML00123610

EXHIBIT H

RETURNED MAIL ONLY - DO NOT MAIL PAYMENTS HERE
PO BOX 8306
CORAL SPRINGS, FL 33075-8306

Patient: **Daniel Kreutzmann**
Printed on: **May 15, 2026**

Difficulty paying your bill?
Visit **pay.amr.net** to learn about 0% interest payment plans and more ways to resolve your balance.

Daniel Kreutzmann
[redacted]

You have $2,532.14 that is covered by your payment plan

You have an active payment plan of **$121.00/month** with **21 payments left**. Your next scheduled payment is on **Jun 11, 2026.**

See back for details →

Amount you owe	**$2,532.14**
Active payment plan	-$2,532.14
Outstanding Amount	**$0.00**

FOLD OR CUT AND DETACH AREA BELOW TO SEND WITH PAYMENT

Ways to Pay

Online

Pay via desktop or mobile:
pay.amr.net

Phone

To pay by our automated phone system, call toll-free 24/7:
(888) 401-3274

Mail

Mail check or money order with this part of the bill to the address on the reverse side.
Do not send cash.

Need Help?

Call our team toll-free
(Mon to Fri 9AM to 8PM EDT)
(800) 913-9106

Daniel's visit on May 1, 2025

Insurance applied | On a payment plan

Location: American Medical Response | Clinician: Amr San Diego Bls Unit 286D

ID: 876-25240749-01

Bill details

Service	Total billed
Bls Non-Emergent Bas	$3,077.50
Wait Time	$198.67
Night Charge	$172.22
Mileage	$93.83
Pulse Oximetry	$82.83

Continued on next page

FOLD OR CUT AND DETACH AREA BELOW TO SEND WITH PAYMENT

Mail this slip with check

Account Holder: **Daniel Kreutzmann**
Bill Amount: **$0.00**
Invoice ID: **876-25240749-01**

MAKE CHECK PAYABLE & MAIL TO:

AMR
PO Box 55418
Los Angeles, CA 90074-5418

Daniel's visit on May 1, 2025 (cont'd)

Insurance applied | On a payment plan

Location: American Medical Response | Clinician: Amr San Diego Bls Unit 286D

ID: 876-25240749-01

Bill details

Service	Total billed
Disp Linen	$19.86

Subtotal billed	$3,644.91
Insurance covered	−$386.77
You previously paid	−$726.00
Amount you owe (subtotal)	**$2,532.14**
Active payment plan	−$3,258.14
Outstanding amount (subtotal)	**$0.00**

Your bill summary

Total billed	$3,644.91
Insurance covered	-$386.77
Total post-insurance	$3,258.14
You paid	-$726.00
Active payment plan	-$2,532.14
Total due	**$0.00**

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Your insurance coverage details

Total billed The original cost of your care billed by provider	$3,644.91
Insurance covered The discounted amount applied by your insurance plus the amount insurance paid	-$386.77
Total post-insurance	**$3,258.14**
Deductible	$0.00
Coinsurance	$0.00
Copay	$0.00
Not covered	$3,258.14

Insurance definitions

Deductible
Amount you pay before insurance starts paying for your covered services

Coinsurance
Partial out of pocket amount you owe once your deductible is fully met

Copay
Flat fee for a service determined by your plan

Not covered
Amount that is not covered by your plan

To request copies of your medical records, go to **medicopy.net/amr** or telephone **866.587.6274**

Want to tell us about your experience or have a question? Please visit **gmr.myemsaccount.com**

Unable to pay your bills?

Financial assistance may be available if you are uninsured or have exhausted your insurance benefits and cannot afford to pay your bill. Please contact our Customer Care Team to inquire about our Compassionate Care Program or download the application here: gmr.net/ccp

Please provide all requested information and mail to the address listed on the application. Those who submit a complete application and qualify based on federal poverty thresholds can receive financial assistance on some or all of the transport charges.

Call us at **(800) 913-9106**

More information at: **gmr.net/ccp**

Affordable Care Act Section 1557 Notice of Nondiscrimination
For a copy of the Notice of Non-discrimination, go to https://www.globalmedicalresponse.com/docs/site/non-discrimination, or contact us at (800) 913-9106.