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September 16, 2022

Tony Kingman
Chief Financial Officer
South San Antonio Independent School District
1450 Gillette Blvd.
San Antonio, TX 78224

RE: Administrative Services Only Account No. 3344553

Dear Tony Kingman:

This letter will serve as an amendment to the Administrative Services Only Agreement between Cigna Health and Life Insurance Company ("**CHLIC**") and South San Antonio Independent School District ("**Employer**"), effective November 1, 2021 (the "**Agreement**").

Effective as of November 1, 2022, the Agreement is hereby amended as set forth below. Any provision or subsection set forth in this amendment shall be deemed to: (a) replace in its entirety the same subsection in the current Agreement; and/or (b) add new provisions or subsections. Only those provisions and subsections set forth in this amendment are deemed amended or added, and all provisions and subsections not identified herein shall be deemed unaffected by this amendment and, accordingly, shall remain in full force and effect.

Section 6, "Claim Audits," of the Administrative Services Only Agreement is hereby amended in its entirety as follows:

Section 6. Audit Rights

a. Employer may audit CHLIC's administration of Plan Benefits in accordance with the following requirements:

   i. Except for clinical audits, Employer shall provide to CHLIC a scope of audit letter and the fully executed Audit Agreement, a sample of which is attached hereto as Exhibit C, together with a forty-five (45) day advance written request for audit. For a clinical audit, Employer shall provide to CHLIC a ninety (90) day advance written request to audit, together with a scope of audit letter, which scope shall be mutually agreed upon between the parties. CHLIC will provide the Auditor and Employer, if Employer is participating in the audit, with a draft Clinical Audit Agreement, sample of which is attached hereto as Exhibit C1, within a week of receiving the request to audit and scope of audit letter.

   ii. Employer may 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 in a virtual/remote audit environment or at CHLIC's office(s), as business needs require.

   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 Audit Agreement attached hereto as Exhibit C and/or Exhibit C1, as applicable, which would hereby be 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 errors requiring adjustments, such adjustments will be made in accordance with this Agreement and based upon the actual claims and fees reviewed and not upon statistical projections or extrapolations.

vi. Employer shall be responsible for its Auditor's costs.

vii. 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).

viii. In no event shall any audit involve Plan benefit payments or administration prior to the most recent two (2) plan years, (unless otherwise noted) or involve Plan benefit payment or administration that has been previously audited.

ix. New audits shall not be initiated until all parties have agreed that the prior audit is closed.

In the event Employer requests to alter the scope of the 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.

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 the following:

- **Claims:** Payment documents relating to a random, statistically valid sample of two-hundred twenty-five (225) claims paid.
    - Requests to review provider contracts will be subject to CHLIC's current criteria and contrary terms in Participating Provider Agreements.
- **Appeals:** Documents, including payment documents as appropriate, relating to a random sample of up to thirty-five (35) appeals.
- **Customer Service:** Documentation and review of call recordings relating to a random sample of up to thirty-five (35) Member calls.
    - CHLIC maintains call recordings for up to twelve (12) months, and any customer service audit is limited to the availability of the call recordings.
- **Accumulator/Combined Deductible:** Audits are allowed based on mutually agreed-upon scope of up to thirty (30) cases.
- **Benefit Implementation:** Audits are allowed based on mutually agreed-upon scope and timing. CHLIC will support the benefit implementation audits for review of benefit set up related to claim processing.
- **Clinical Cases/Calls**: The standard annual allowable number of cases/calls for audit and standard number of days allowed to conduct the audit is as follows, based on number of Employer Subscribers during the time period covered by the audit:

Number of Subscribers	# Cases	# Calls	# Days*
5,000 & under	10	3	1

>5,000 & < 25,000	15	4	1
>25,000 & < 75,000	20	5	1.5
>75,000	25	6	2

All cases and calls related to case selection will be prepared and presented in compliance with all Applicable Laws, Privacy Addendum in Exhibit D, including but not limited to the HIPAA Privacy and Security Rules and 42 C.F.R. Part 2.. Cases selected will have been managed during the rolling twelve (12) month period prior to the date of the written request to conduct an audit and not previously audited for the current audit scope.

- **Medical Cost Containment Program Fees (MCCP):** MCCP audits are limited to confirmation of fees paid by the Employer related to the programs in place. The audits will not include review of documentation that is not applicable to claim administration. In addition, Auditor agrees that it will not outreach to Participating Providers or Members for claim or medical record information.

  MCCP fee audits are based on the following criteria:

  - Random samples selected by CHLIC based on the following:
    - Twenty-five (25) claims in which fees were paid for the Non-Participating Provider Cost Containment Programs which include Network Savings Program; Supplemental Network and Medical Bill Review (Pre-payment Cost Containment for Non-contracted claims)
    - One-hundred (100) claims related to Other Cost Containment Programs which include Medical Bill Review (Bill Audit; DRG Validation Audits and Recovery; Medical Implant Device Audits); COB Vendor Recoveries; Secondary Vendor Recovery Program; Provider Credit Balance Program; High Cost Specialty Pharmaceutical Audits; Eligibility Overpayment Recovery Vendor Services; Class Action Recoveries and Subrogation/Conditional Claim Payment.

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

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) by giving Employer at least sixty (60) days' prior written notice, (ii) upon any modification or amendment of the benefits under the Plan, (iii) upon any variation of ten percent (10%) 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.

Section 9, "Modification of Agreement," of the Administrative Services Only Agreement is hereby amended in its entirety as follows:

Section 9. Modification of Agreement

Except as otherwise provided for 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 8by CHLIC providing written notice to Employer and Employer indicating its acceptance of the modification either by paying the revised charges or failing to object to such revised charges in writing to CHLIC within fifteen (15) business 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 20, "Identifying Information, Internet Usage, and Trademark," of the Administrative Services Only Agreement is hereby amended in its entirety as follows:

Section 20. Identifying Information, Internet Usage and Trademark

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

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

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

Exhibit C1, "Clinical Audit Agreement (Sample)," of the Administrative Services Only Agreement is hereby added to the Administrative Services Only Agreement as attached hereto.

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

The terms of the Administrative Services Only Agreement identified above, as mentioned herein, will be effective as of November 1, 2022. Please indicate your agreement to the amendment by signing the enclosed copy of this letter where indicated and returning it to me. Alternatively, this amendment shall become effective on the effective date indicated unless Employer notifies CHLIC either electronically or in writing (at the address indicated above) within sixty (60) days of the date of this letter that it does not accept all the terms of this amendment notwithstanding any provision to the contrary in the Administrative Services Only Agreement. In that case, CHLIC shall cooperate to negotiate mutually agreeable terms with Employer. Once agreement with respect to the terms of the amendment is reached, the amendment will apply retroactively to the effective date.

Sincerely,

Aimee E. Burnham
Its Contractual Agreement Unit Manager
Duly Authorized
Cigna Health and Life Insurance Company

Accepted by: **SOUTH SAN ANTONIO INDEPENDENT SCHOOL DISTRICT**

By: _____

Name: _____

Title: _____

Executed this ____ day of _____, in the year _____

Schedule of Financial Charges

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

	MEDICAL ADMINISTRATION CHARGES	
Product	**Description**	**Charge**
Medical	Open Access Plus (OAP) with Care Management Preferred	**$19.57/employee/month**
	MEDICAL NETWORK ACCESS FEE, UTILIZATION MANAGEMENT FEE AND OPTIONAL PROGRAM FEE	
Product	**Description**	**Charge**
Medical	OAP Access Fee	**$18.57/employee/month** **Included in Medical Administration Charge**

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

CIGNA HOME DELIVERY PHARMACY DISCLOSURE		
	Product	**Charge**
Cigna Home Delivery Pharmacy (a CHLIC affiliated company(ies))	Specialty drugs dispensed by Cigna Home Delivery Pharmacy and administered under the Plan's medical benefit. "Cigna Home Delivery Pharmacy" means a duly licensed pharmacy operated by CHLIC or its affiliates, where prescriptions are filled and delivered via the mail service. Cigna Home Delivery Pharmacy may maintain product purchase discount arrangements and/or fee-for-service arrangements with pharmaceutical manufacturers and wholesale distributors. Cigna Home Delivery Pharmacy contract for these arrangements on its own account in support of its pharmacy operations. These arrangements relate to services provided outside of this Agreement and other pharmacy benefit management arrangements and may be entered into without regard to whether a specific drug is on one of the formularies that CHLIC offers to entities like Employer that sponsor group health plans. Discounts and fee-for-service payments received by Cigna Home Delivery Pharmacy are not part of the administrative fees or other charges paid to CHLIC in connection with CHLIC's services hereunder. This provision shall survive termination or expiration of the Agreement.	**The drug's charge under a national specialty drug discount schedule that generates a 19.00% 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		
OAP	Run-Out Period of twelve (12) months	**No Additional Cost**

CHLIC MEDICAL COST CONTAINMENT FEES
CHLIC administers the programs listed below to contain costs with respect to charges for health care service/supplies that are covered by the Plan (the "Cost Containment Programs"). In administering these Cost Containment Programs, CHLIC may contract with vendors to perform various tasks related to the Cost Containment Programs. These Cost Containment Programs include services that are performed on claims that are subject to the federal No Surprises Act and are not otherwise subject to state law ("NSA Services"). CHLIC's charge for administering a Cost Containment Program is the applicable percentage indicated in the table below of the: 1) "gross savings" (i.e., the difference between the charge the provider made and the allowable amount resulting from the Cost-Containment Program); 2) "net savings" (i.e., the gross savings less the applicable vendor charge); or

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

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

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

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

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

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

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

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

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

a. the amount of the non-Participating Provider's billed charge not exceeding the greater of a CHLIC determined percentage of the Medicare allowable amount (the 80th percentile of the reasonable and customary charge if there is no Medicare allowable charge) or

	the amount required by state or federal law (in some instances, the patient may be balance billed by the non-Participating Provider if the provider's charge exceeds such amount), or b. the provider's billed charge.	
Non-Participating Provider Cost Containment Programs for Services/Supplies that are not NSA Services		
1.	Network Savings Program	**29% of net savings**
2.	Supplemental Network	**29% of net savings**
3.	Medical Bill Review – (Pre-payment Cost Containment for Non-contracted claims):	
	Inpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**Lesser of 5% of hospital bill or the gross savings achieved**
	Outpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
	Physician/Professional Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
4.	For employers that are subject to state laws providing protections from surprise bills: Payment based on amounts other than Network Savings Program, Supplemental Network, and Medical Bill Review. These payments include amounts determined through negotiation or independent dispute resolution under state law. (The charges indicated in the column to the right include the fees charged by government departments or agencies for administering the independent dispute resolution process and the fees charged by entities conducting independent dispute resolution.)	**29% of net savings**

B. Cost Containment for NSA Services

For NSA Services, CHLIC will issue initial payments at amounts determined by CHLIC or its vendors ("Initial Allowed Amount"). The Initial Allowed Amount may be based on Discounts and may be higher than, equal to, or lower than the qualifying payment amount, as calculated by CHLIC ("QPA"). Patient cost-share will be based on the lower of the QPA, the non-Participating Provider's billed charges, the amount determined by CHLIC to be required by state law (if applicable), or the Initial Allowed Amount. Patient cost-share will not increase as a result of negotiations or independent dispute resolution determinations under the No Surprises Act. If additional payment above the Initial Allowed Amount is owed as a result of negotiations or independent dispute resolution under the No Surprises Act, CHLIC, as agent for the Employer, shall make Bank Account Payments from the Bank Account in the amount of such additional payment.

Non-Participating Provider Cost Containment Programs for NSA Services		
1.	Network Savings Program	**29% of net savings**
2.	Supplemental Network	**29% of net savings**
3.	Medical Bill Review – (Pre-payment Cost Containment for Non-contracted claims):	
	Inpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**Lesser of 5% of hospital bill or the gross savings achieved**
	Outpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
	Physician/Professional Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
4.	Payment based on amounts other than Network Savings Program, Supplemental Network, and Medical Bill Review. These payments include amounts determined through negotiation or independent dispute resolution under the No Surprises Act. (The charges indicated in	**29% of net savings**

	the column to the right include the fees charged by government departments or agencies for administering the independent dispute resolution process and the fees charged by entities conducting independent dispute resolution.)	
C. Other Cost Containment Programs		
1.	Clinical Complex Claim Review – (Pre- or Post-payment Cost Containment for Non-contracted and Contracted claims):	
	• Bill Audit	**29% of the gross savings/gross recovery achieved plus hospital fees or expenses passed through**
	Diagnosis Related Grouping (DRG) Validation/Audits and Recovery. An overpayment audit and recovery program in which CHLIC or its vendors review paid claim data to identify overpayments based on inaccurate DRG coding.	**29% of gross savings/gross recovery plus any fees or expenses passed through by the hospital or regulatory agency**
	• Medical Implant Device Audits	**29% of the gross savings/gross recovery**
2.	COB Vendor Recoveries [Exclusive of pharmacy programs where claims are adjudicated at time prescription is received.]	**29% of the gross recovery**
3.	Secondary Vendor Recovery Program	**29% of the gross recovery**
4.	Provider Credit Balance Recovery Program	**29% of the gross recovery**
5.	High Cost Specialty Pharmaceutical Audits (this service is only provided with respect to Medical coverage)	**29% of the gross recovery**
6.	Eligibility Overpayment Recovery Vendor Services. Identification and recovery of funds in situations where the overpayment is due to the late receipt of Member termination information. (This service is only provided with respect to Medical coverage).	**29% of the gross recovery**

7.	Class Action Recoveries	**35% of the gross recovery**
8.	Subrogation/Conditional Claim Payment. Identification, investigation and recovery of claim payments involving other party liability or where another entity is responsible for payment (including by way of example but not by limitation automobile insurance, homeowner insurance, commercial property insurance, worker's compensation). (This service is only provided with respect to Medical coverage.)	**5% of the gross recovery plus litigation costs if counsel is retained and an appearance is filed on behalf of CHLIC or Employer in any litigation, or a lawsuit is filed on their behalf;** **29% of the gross recovery if no counsel is retained and in all other instances, including cases where state law requires that employee benefit plans be named as party defendants or involuntary plaintiffs.**

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

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

CARE MANAGEMENT/COST CONTAINMENT PROGRAM FEES		
	CHLIC arranges for third parties to provide care management services to: (i) contain the cost of specified health care services/items overall with respect to all plans insured and/or administered by CHLIC, and/or (ii) improve adherence to evidence based guidelines designed to promote patient safety and efficient patient care. Charges for these services will be processed through the Bank Account.	**Specific vendor fees and care management program services are available upon request.**
	Medical Management (inclusive of Medical Necessity Review) of Chiropractic services.	**National Average is $0.16 PMPM; rates vary by market and are available upon request.**
	In addition to such third parties, CHLIC has arranged for an affiliate, eviCore, to provide the following care management/cost-containment programs:	
	Pre-certification of coverage of radiation therapy services.	**$885.00 per episode of care (EOC)** **Effective January 1, 2023:** **$912.00 per episode of care (EOC)**
	Pre-certification of coverage of diagnostic cardiology services. *(If Employer has elected Basic Standard Medical Management (see Administration Charges section above) this program and charge is not applicable to that membership).*	**$0.19 PMPM**
	Pre-certification of coverage of medical oncology services.	**$1,000.00 per episode of care (EOC)** **Effective January 1, 2023:** **$1,050.00 per episode of care (EOC)**

	Pre-certification of coverage of musculoskeletal therapy services. *(If Employer has elected Basic Standard Medical Management (see Administration Charges section above) this program and charge is not applicable to that membership).*	**$0.39 PMPM** **Effective January 1, 2023:** **$0.40 PMPM**
	Services related to the coverage of high tech radiology which may include pre-certification. In certain instances, the Plan will pay eviCore a fee on a per member/per month basis for pre-certification, arranging care, and other services that eviCore may render. Such reimbursement will be in addition to the amount that the Plan pays to reimburse the provider through which eviCore arranged for the provision of the service or supply, which will be based on eviCore's contracted rate with that provider. In such instances, Plan Benefits and member cost-share will be determined based on the rate that eviCore contracted to pay the provider for the provision of the service or supply. *(If Employer has elected Basic Standard Medical Management (see Administration Charges section above) this program and a charge is not applicable to that membership).* eviCore may also charge for services related to the provision of high tech radiology as described below in "Other Vendors and Health Care Services Providers."	**Fee reimbursement method and rates may vary by market and are available upon request**.
	Pre-certification of coverage of gastroenterology services. *(If Employer has elected Basic Standard Medical Management (see Administration Charges section above) this program and charge is not applicable to that membership).*	**$0.09 PMPM**
	Pre-certification of coverage for appropriate setting of care/service for high tech radiology services *(If Employer has elected Basic Standard Medical Management (see Administration Charges section above) this program and charge is not applicable to that membership).*	**No more than $0.20 PMPM. Billing method may vary by market and is available upon request.**
	Pre-certification of coverage for appropriate setting of care/service for certain medical oncology drugs (redirection may be to Accredo, a CHLIC affiliate).	**30.00% of shared savings (where savings is derived from the difference between**

		drug dose cost at higher cost provider initially requested and drug dose cost at lower cost provider). Fee shall not exceed $5,000.00 per dose for a maximum of three doses resulting in a maximum total of $15,000.00. Note: CHLIC may retain a portion of the shared savings fee before reimbursing eviCore.
	Pre-certification of coverage of sleep management services. *(If Employer has elected Basic Standard Medical Management (see Administration Charges section above) this program and charge is not applicable to that membership).*	**$0.10 PMPM** **Effective January 1, 2023:** **$0.11 PMPM**
	Network management and care coordination of coverage of home health, durable medical equipment and home infusion services.	**$0.30 PMPM** **Effective January 1, 2023:** **$0.31 PMPM**
	CHLIC may revise charges/fees by giving Employer at least sixty (60) days' prior written notice.	
EXTERNAL REVIEW AND CONSULTATIVE REVIEW FEES		
	When a Member elects an External Review (as that term is defined in the Patient Protection and Affordable Care Act (PPACA)) of a benefit determination by an independent third party, the cost of a specific third party review is dependent on the nature and complexity of the issue on appeal. Third party review charges will be commensurate with the level of expertise necessary and the time required to complete the review.	**$500-$1,500 Review**

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

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

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

COMPLIANCE ASSISTANCE		
	CHLIC shall provide the following services to assist Employer in meeting its compliance obligations under section 2715 of the Public Health Service Act as added by the Patient Protection and Affordable Care Act and applicable regulations with respect to the provision of the Summary of Benefits and Coverage ("**SBC**"), translation notice and glossary. Applicable to all medical plans including HRA and FSA which are considered "group health plans" subject to the SBC requirements.	
1.	Preparation of SBC, translation notice. CHLIC will not be responsible for any changes that Employer makes to the SBC.	**No charge**
2.	Provide SBC, translation notices prepared by CHLIC to Employer electronically as well as any updates or material modifications.	**No charge**
3.	Include in SBC a summary of benefits administered by carve-out vendor if Employer or carve-out vendor provides CHLIC with necessary carve-out benefit information at least twelve (12) weeks prior to the date the SBCs are to be delivered to Employer.	**$500 for each benefit option under the Plan for which carve-out vendor benefits are included in SBC**
ADDITIONAL SERVICES		
Service	**Description**	**Charge**
Behavioral Health	Access to inpatient and outpatient behavioral health services and focused utilization review and case management for both inpatient and outpatient, in-network behavioral health services.	**For OAP Products: Included in Medical Access Fee (All Members)**
Clinical Program	A targeted condition medication therapy management program in which CHLIC provides support for Members using specialty medications for certain chronic conditions and that are obtained or administered at retail pharmacies or outpatient, office or home health care settings. As part of the program, Members are counseled on their condition, medication side effects, and importance of adherence. For the sake of clarity, if a specialty pharmacy affiliate of CHLIC provides therapy management for specialty medications the pharmacy dispenses to Members, then it does so in its capacity as a specialty pharmacy and not on behalf of CHLIC; CHLIC does not exert direction or control over the pharmacists at any specialty pharmacy affiliate.	**For OAP Products: 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	**For OAP Products: Included in Medical Access Fee**
One Guide	The One Guide advocacy solution utilizes a multimodal approach to support members and help them successfully navigate the health care system. Members are serviced by personal guides that include frontline service staff, as well as clinicians and non-clinician support staff from our medical, behavioral and pharmacy programs. In addition to connecting with personal guides via telephone, members can also interact with personal guides via the click-to-chat feature on myCigna.com (web and app), enabling members to engage with CHLIC and One Guide in the way in which they prefer. One Guide helps simplify and strengthen the connection between members, their benefit plan, and their overall health and well-being. Through personalized and relevant messaging, One Guide proactively engages members with clear ways to save money, stay healthy, and improve health outcomes that lead to a healthy lifestyle. One Guide offers: • education on health plan features, account balances and ways to maximize benefits and earn available incentives • guidance in finding the right doctor, lab, convenience care or pharmacy	**For OAP Products: Included in Medical Access Fee**

	• immediate connection to health coaches and other resources The goal of One Guide is to help Members take care of what matters most- staying healthy, saving money, and improving health.	
Tiered Benefits	Tiered Benefits is a tiered benefit plan design option made available in certain geographies to groups sponsoring group health benefit plans. Participants with the tiered benefit design are afforded a lower copay or coinsurance level for covered services provided by Tier 1 physicians than if they select an in-network, non- Tier 1 physicians. Tier 1 designated providers may include primary care providers and certain specialists that have the "Cigna Care Designation" and/or are designated as "Tier 1 Provider". Those primary care providers and specialists get "Cigna Care Designation" status by meeting or exceeding specific quality and cost efficiency criteria.	**For OAP Products: Included at No Additional Cost**
Transparency in Coverage and Consolidated Appropriations Act, 2021	CHLIC will make available an internet-based self-service tool for use by Members, as well as certain data in machine-readable file format on a public website, as required under the Transparency in Coverage rule. Members can access the cost estimator tool on myCigna.com. Updated machine-readable files can be found on Cigna.com and/or CignaForEmployers.com on a monthly basis. Pursuant to Consolidated Appropriations Act (CAA), Section 106, CHLIC will submit certain air ambulance claim information to the Department of Health and Human Services (HHS) in accordance with guidance issued by HHS. Subject to change based on government guidance for CAA Section 204, CHLIC will submit certain prescription drug and health care spending information to HHS through Plan Lists Files (P1-P3) and Data Files (D1-D8) (D1-D2 for employers without integrated pharmacy product) aggregated at the Market Segment and State level, as outlined in guidance.	**Included in Medical Administration Fee**

Health Improvement Fund		
Health Improvement Fund	For clinical/wellness/behavioral programs offered by CHLIC that are purchased, CHLIC will establish a Health Improvement Fund in the amount of $75,000.00. This fund will be used to defray the cost of CHLIC designated and arranged health and wellness improvement programs (e.g. biometric screenings, flu shots) for Employees of Employer and to reward participation in these programs. The Health Improvement Fund is a one-time credit to be used from November 1, 2022-October 31, 2023. Unused funds cannot be rolled over and CHLIC must pre-approve use of the Health Improvement Fund. The Health Improvement Fund shall be extinguished upon notice of termination of the Agreement and any fund amount not used prior to the notice of termination of the Agreement shall only be available to Employer for the purpose of funding the cost of those reimbursable services provided prior to such notice of termination.	

Exhibit B – Services

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

	Perform, based on CHLIC's book of business internal audits of plan benefit payments on a random sample basis.	**All Products**
	Claim control procedures reported annually in Statement on Standards for Attestation Engagements (SSAE) No. 18 Report (or any applicable successor thereto).	**All Products**
	Respond to Insurance Department complaints.	**All Products**
	Designated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Products**
	Member Explanation of Benefit ("**EOB**") statements including, when applicable, notice of denied claims, denial reason(s) and appeal rights.	**All Products (excluding Pharmacy)**
	Verify enrollment and eligibility using Member information submitted by Employer and/or its authorized agent.	**All Products**
Medical Only		
	CHLIC's generic enrollment form is made available to Employer and eligible individuals.	**All Medical Products**
	CHLIC's standard ID card with toll-free telephone number are prepared and delivered to Members.	**All Medical Products**
	Administration of subrogation/conditional Claim Payment (terms described in Exhibit E).	**All Medical Products**
PLAN BOOKLET		
	Prepare and make accessible Member benefit booklet drafts to Employer.	**All Products**
UNDERWRITING SERVICES		
	5500 Schedule C reporting.	**All Products**
	5500 Schedule A or Annual Reconciliation Disclosure reporting (when applicable)	**All Products**
	CHLIC's standard Underwriting services: a) benefit design analysis b) projected cost analysis.	**All Products**
HIPAA INDIVIDUAL RIGHTS		
	Handling of requests from Members for access to, amendment and accounting of protected health information, and requests for restrictions and alternative communications as required under federal HIPAA law and regulations, as set out in this Agreement and its Exhibits.	**All Products**

COST CONTAINMENT		
	Maximum reimbursable charge determinations of non-Participating Provider charges for covered services.	**All Medical Products (with out-of-network benefits)**
	CHLIC's standard cost containment controls: Application of non-duplication and coordination of benefits rules and coordination with Medicare.	**All Medical Products**
	Delivery of information, as necessary, regarding standard application of non-duplication or coordination of benefits.	**All Medical Products**
	Review of medical bills in accordance with CHLIC's then current Medical Bill Review program.	**All Medical Products**
	Medical Cost Containment, as described in the Schedule of Financial Charges.	**All Medical Products**
	Annual reporting of CHLIC's standard cost containment results upon Employer's request.	**All Medical Products**
REPORTING		
	Summary reports of medical cost and utilization experience (where applicable), upon completion of internal report generation, are available through Cigna's web site, CignaforEmployers.com.	**All Medical Products**
	Claim Reporting: CHLIC will provide standard banking and financial report information based upon paid claim data. CHLIC will not provide information on incurred-but-not reported claims, projected claims, pre-certifications of coverage, case management information or information on a Member's prognosis or course of treatment.	**All Medical Products**
	Individual Stop Loss Reporting is an optional service provided at an additional fee to employers who have individual stop loss through another entity other than CHLIC. CHLIC will provide its standard Individual stop loss reporting package, which includes banking and financial information based upon paid claims data, only after the stop loss carrier and Employer have executed CHLIC's standard Hold Harmless/Confidentiality Agreement. Aggregate Stop Loss Reporting is not included as part of the standard reporting package and is not provided. CHLIC will not provide documentation and information, including but not limited to, incurred-but-not-paid claims, projected claims, pre-certifications of coverage, case management records and notes, course of treatment or prognosis, and internal audits. CHLIC does not allow stop loss carriers to audit CHLIC's claims administration under the medical benefit plan, however, the Employer's audit rights are set forth in the Agreement. For the sake of clarity, as it is possible that certain information, documentation, data and/or reports that are required by the stop loss carrier prior to reimbursement under Employer's	**All Medical Products**

	stop loss policy will not be available for stop loss policy administration, Employer is responsible for verifying any such required information with its stop loss carrier.	
MEMBER EXTERNAL REVIEW PROGRAM		
	CHLIC contracts with a minimum of three (3) independent review organizations that meet the Patient Protection and Affordable Care Act (PPACA) external review requirements. Members may appeal eligible claims requiring medical judgment to an external independent review organization which is selected by CHLIC on a random basis. If Employer has chosen not to participate in this program, the Employer may be responsible for making other arrangements to meet the Patient Protection and Affordable Care Act (PPACA) external review requirements.	**All Medical Products**
MEDICAL MANAGEMENT SERVICES		
	CHLIC provides integrated medical management that includes (depending upon the terms of the Plan) the following core services.	
	Pre-Admission Certification and Continued Stay Review (PAC/CSR) services to certify coverage of acute and sub-acute inpatient admissions/stays or provides guidance to appropriate alternative settings. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products**
	Case Management, a service designed to provide assistance to a Member who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support.	**All Medical Products**
	Assist providers with resources and tools to enable them to develop long term treatment plans in the management of chronic or catastrophic cases.	**All Medical Products**
	The Cigna HealthCare Healthy Babies Program is an educational program which provides Member with prenatal care education and resources to help them better manage their pregnancy. Other benefits of this program include the Health Information Line, high risk maternity and pregnancy information on myCigna.com.	**All Medical Products**
	HealthCare Cost and Quality tools available on myCigna.com and myCigna mobile app.	**All Medical Products**
	A panel of physicians and other clinicians to assess the safety and effectiveness of new and emerging medical technologies. The panel meets monthly to review and update coverage policies.	**All Medical Products**
	Health Information Line is a service that provides twenty-four (24) hour toll free access to nurses who provide convenient and confidential services. Health Information Line nurses can help guide Members in finding the right care, make informed decisions about symptom-based health issues the Member is experiencing when they call the Health Information Line and recommend appropriate	**All Medical Products**

	settings for care. Health Information Line nurses can help inform and educate Members about a wide variety of health and medical information, including access to a library of English and Spanish podcasts.	
	Cigna LifeSOURCE Transplant Network® contracts with more than one hundred seventy (170) independent transplant facilities which includes over eight hundred (800) transplant programs and provides access to solid organ and bone marrow/stem cell transplantation while improving cost containment and reducing financial risk.	**All Medical Products**
	A health education program that delivers mailings to Members with certain conditions.	**All Medical Products**
	Behavioral health services are provided/arranged by a CHLIC affiliate (details available upon request), including utilization review and case management for both inpatient and outpatient, in-network behavioral health services.	**OAP Products:** **(All Members)**
	Implement a quality oversight process that includes monitoring of utilization management performance measurements and a continuous quality improvement process when warranted.	**All Medical Products**
	Transition of care services to allow Members with defined conditions to continue treatment with non-Participating Providers after enrollment for continued uninterrupted care for a limited time.	**All Medical Products Except Comprehensive and Indemnity**
	Focused utilization management of outpatient procedures and identification of appropriate alternatives. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products with Care Management Preferred**
NETWORK MANAGEMENT SERVICES		
	CHLIC, and/or its affiliates or contracted vendors shall:	
	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, fixed per person per period, per diem charges, incentive bonuses, case rates, withholds etc.). The amount and type of negotiated reimbursement may vary depending upon the type of plan. For example, a hospital may accept less for patients enrolled in certain types of plans than others. In addition, CHLIC may contract with Participating Providers and other parties (for example Independent Practice Associations) for performance-based incentive payments to promote quality of care, patient safety and cost efficiency.	**All Medical Products**

	Credential and re-credential Participating Providers in accordance with CHLIC's credentialing requirements and ensure that third-party network vendors credential/re-credential Participating Providers in accordance with CHLIC's requirements;	**All Medical Products**
	Monitor Participating Provider compliance with protocols and procedures for quality, Member satisfaction, and grievance resolution;	**All Medical Products**
	Facilitate the identification of Participating Providers by Members; and	**All Medical Products**
	Designated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Medical Products**
	Access to online and/or on demand medical and health-related consultations via secure telecommunications technologies, telephones and internet are permitted and may include MDLIVE, a CHLIC affiliate (see details on myCigna.com).	**All Medical Products**
CIGNA STAFF MODEL HEALTHPLAN SERVICES		
	The Cigna HealthCare of Arizona, Inc. staff model ("**Cigna Medical Group**" or "**CMG**") is a multispecialty participating provider group located in metropolitan Phoenix, Arizona. CMG's integrated care delivery model and population health management team work together to facilitate the way in which patients and doctors communicate and interact in order to increase patient satisfaction and improve health outcomes. Plan Participants may at some time receive treatment from a CMG facility or provider even if they do not reside in Arizona (as when traveling). Plan Participants utilizing Cigna participating provider networks in Arizona may access certain specialty and/or ancillary services (such as imaging and urgent care services) through the CMG system. For covered services provided to Participants, CMG is paid at the rates in effect at the time of service (as may be revised from time to time). Representative rates for routinely performed services are attached to the Schedule of Financial Charges herein. A complete copy of the rates is available on request under a mutually agreed nondisclosure agreement ("**NDA**"). If the Plan requires or allows Participants to select a primary care provider ("**PCP**"), Phoenix area Participants who do not select a PCP during open enrollment may be assigned to or otherwise encouraged to consider a CMG PCP. CMG has established collaborative referral relationships with	**All Medical Products**

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

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

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

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

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

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

Exhibit C1 – Clinical Audit Agreement (Sample)

A. WHEREAS, Cigna Health and Life Insurance Company ("CHLIC") desires to cooperate with a request by ("Employer") to permit a clinical 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 clinical services administered by CHLIC;

C. WHEREAS, in the course of conducting the Audit, Auditor will come into possession of certain confidential and proprietary information relating to individuals who are recipients of CHLIC's services, medical providers who provide health services, and trade secrets of CHLIC (the "Information"); and

D. WHEREAS, the Auditor and the Employer recognize CHLIC's legitimate interests in maintaining the confidentiality of its Information, protecting its business reputation, avoiding unnecessary disruption of its service 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 ninety (90) days prior to the commencement of the Audit the following "Audit Specifications":

a. the name, title and professional qualifications of individual Auditors;

b. the date(s), the length of time contemplated as necessary to complete the Audit, and clinical operations location, if any to be audited; or, if the Audit is to be performed virtually, the Internet Protocol (IP) address and physical location from the individual auditors will remotely access the records/information required for the purposes of the Audit;

c. the Audit period;

d. the Audit objectives;

e. the scope of the Audit (time period, diagnosis, enrollee participation in programs and number of claims/calls);

i. Standard number of cases/calls is as follows;

Number of Subscribers	# Cases	# Calls	# Days*
5,000 & under	10	3	1
>5,000 & < 25,000	15	4	1

>25,000 & < 75,000	20	5	1.5
>75,000	25	6	2

**Takes into consideration length of time to complete the standard # cases and calls based on an one (1) year lookback scope period.*

f. the process by which cases and calls will be selected for audit; and

g. the records/information required by the Auditor for purposes of 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 D above. Any additional costs incurred by CHLIC to accommodate unusual audit specifications will be reimbursed as mutually agreed upon by the parties.

3. Access to Information

For onsite Audits, CHLIC will make the Information called for in the Audit Specifications available to the Auditor at a mutually acceptable time and place.

For virtual audits performed from a remote access point, CHLIC will make the Information called for in the Audit Specifications available to Auditor at a mutual acceptable time via connection to a secure service. Access is subject to CHLIC's verification that each individual auditor meets and complies with CHLIC's remote access standards and other security requirements.

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 before the Audit findings and the Audit Report are submitted to the Employer to allow CHLIC the opportunity to review and respond to Audit findings and Report prior to Auditor sending finalized versions to Employer.

5. Comment on Audit Report

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

6. Confidentiality

The Auditor understands that CHLIC is permitting the Auditor to review the Information solely for purposes of the Audit. Accordingly, the Auditor will ensure that all Information will be kept confidential in accordance with all with all Applicable Laws, Privacy Addendum in Exhibit D, including but not limited to the HIPAA Privacy and Security Rules and 42 C.F.R. Part 2. Without limiting the generality of the foregoing, the Auditor specifically agrees to adhere to the following conditions:

a. The Auditor shall not copy, print, photograph or otherwise duplicate or remove any of the Information without the express written consent of CHLIC;

b. The Auditor shall not record any virtual session that includes Protected Health Information as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"); and

c. The Auditor shall not take any screenshots during any virtual session; and

d. The Auditor agrees that it's Audit Report or any other summary prepared in connection with the Audit shall contain no individually identifiable information.

e. Notwithstanding anything to the contrary stated herein, it is understood and agreed by the parties that the Auditor may include and retain the statistical results of the Audit (performance measures expressed as percentages) in its comparative database for the purpose of comparing the results of the Audit with other audits performed by the Auditor. In no event will the results of the Audit included in the comparative database be used or disclosed in any way that identifies Cigna, Employer, or any individual; and

f. Except with regard to Protected Health Information (solely with regard to (i)-(iv) below), this Agreement does not apply or restrict the Auditor from using or disclosing information:

i. Which is or becomes public other than through a breach of this Agreement;

ii. Already known to Auditor prior to the date of this Agreement and with respect to which the Auditor does not have an obligation of confidentiality;

iii. Which is disclosed to the Auditor by a person or entity not party to this Agreement and who is entitled to disclose such information without breaching an obligation of confidentiality;

iv. To Auditor's legal counsel, subject to the confidentiality obligations in this Agreement; or

v. Required to be disclosed by law, whether under an order of a court, government tribunal or other legal process, except that if required by law, Auditor will disclose only the minimum information required to comply with legal mandate.

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:_____

Exhibit E – Conditional Claim/Subrogation Recovery Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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