SERVICES AGREEMENT

THIS SERVICES AGREEMENT ("Agreement") is made as of this first day of January 1, 2022 ("Effective Date"), by and between Pinellas County, a political subdivision of the State of Florida ("County" or "Employer"), and Cigna Health and Life Insurance Company (CHLIC) and Cigna Behavioral Health, Inc., ("Contractor") (individually, "Party," collectively, "Parties").

W I T N E S S E T H:

WHEREAS, the County requested proposals pursuant to 21-0162-P(LN) "RFP" for Medical, Employee Assistance And Managed Behavioral And Mental Health Benefits – Group Personnel Services Services; And

WHEREAS, based upon the County's assessment of Contractor's proposal, the County selected the Contractor to provide the Services as defined herein; and

WHEREAS, Contractor represents that it has the experience and expertise to perform the Services as set forth in this Agreement.

NOW, THEREFORE, in consideration of the above recitals, the mutual covenants, agreements, terms and conditions herein, and other good and valuable consideration, the receipt and sufficiency of which is hereby mutually acknowledged, the Parties agree as follows:

1. Definitions.

"**Agreement**" means this Agreement, including all Exhibits, which are expressly incorporated herein by reference, and any amendments thereto.

"Applicable Law" means the state, federal and/or international law and/or regulation that apply to a Party or the Plan.

"Bank Account" means a benefit plan account with a bank designated by Contractor; established and maintained by Employer in it's or a nominee's name.

"**County Confidential Information**" means any County information deemed confidential and/or exempt from Section 119.07, Florida Statutes, and Section 24(a), Article 1 of the Florida Constitution, or other applicable law, including, but not limited to, data or information referenced in HIPAA/HITECH, and any other information designated in writing by the County as County Confidential Information.

"**Contractor Confidential Information**" means any Contractor information that is designated as confidential and/or exempt by Florida's public records law, including information that constitutes a trade secret pursuant to Chapter 688, Florida Statutes, and is designated in this Agreement or in writing as a trade secret by Contractor (unless otherwise determined to be a public record by applicable Florida law). Notwithstanding the foregoing, Contractor Confidential Information does not include information that: (i) becomes public other than as a result of a disclosure by the County in breach of the Agreement; (ii) becomes available to the County on a non-confidential basis from a source other than Contractor, which is not prohibited from disclosing such information by obligation to Contractor; (iii) is known by the County prior to its receipt from Contractor without any obligation or confidentiality with respect thereto; or (iv) is developed by the County independently of any disclosures made by Contractor.

"**Contractor Personnel**" means all employees of Contractor, and all employees of subcontractors of Contractor, including, but not limited to temporary and/or leased employees, who are providing the Services at any time during the project term.

ERISA means the Employee Retirement Income Security Act of 1974, as amended and related regulations. Contractor acknowledges that County's Plan may not be subject to ERISA.

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

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

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 Contractor to provide services and/or products to Members.

Party/Parties means County and Contractor, 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.

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.

Services means the work, duties and obligations to be carried out and performed safely by Contractor under this Agreement, as described throughout this Agreement and as specifically described in Exhibit A ("Statement of Work") attached hereto and incorporated herein by reference. As used in this Agreement, Services shall include any component task, subtask, service, or function inherent, necessary, or a customary part of the Services, but not specifically described in this Agreement, and shall include the provision of all standard day-to-day administrative, overhead, and internal expenses, including costs of bonds and insurance as required herein, labor, materials, equipment, safety equipment, products, office supplies, consumables, tools, postage, computer hardware/software, telephone charges, copier usage, fax charges, travel, lodging, and per diem and all other costs required to perform Services except as otherwise specifically provided in this Agreement.

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

2. Conditions Precedent. This Agreement, and the Parties' rights and obligations herein, are contingent upon and subject to the Contractor securing and/or providing the performance security, if required in Section 3, and the insurance coverage(s) required in Section 13, within ten (10) days of the Effective Date. No Services shall be performed by the Contractor and the County shall not incur any obligations of any type until Contractor satisfies these conditions. Unless waived in writing by the County, in the event the Contractor fails to satisfy the conditions precedent within the time required herein, the Agreement shall be deemed not to have been entered into and shall be null and void.

3. Services.

A. Services. The County retains Contractor, and Contractor agrees to provide the Services. All Services shall be performed to the satisfaction of the County and shall be subject to the provisions and terms contained herein and the Exhibits attached hereto.

B. Services Requiring Prior Approval. Contractor shall not commence work on any Services requiring prior written authorization in the Statement of Work without approval from the Director of Human Resources.

C. Additional Services. From the Effective Date and for the duration of the project, the County may elect to have Contractor perform Services that are not specifically described in the Statement of Work attached hereto but are related to the Services ("Additional Services"), in which event Contractor shall perform such Additional Services for the compensation specified in the Statement of Work attached hereto. Contractor shall commence performing the applicable Additional Services promptly upon receipt of written approval as provided herein.

D. De-scoping of Services. The County reserves the right, in its sole discretion, to de-scope Services upon written notification to the Contractor by the County. Upon issuance and receipt of the notification, the Contractor and the County shall enter into a written amendment reducing the appropriate Services Fee for the impacted Services by a sum equal to the amount associated with the de-scoped Services as defined in the payment schedule

in this Agreement, if applicable, or as determined by mutual written consent of both Parties based upon the scope of work performed prior to issuance of notification.

E. Independent Contractor Status and Compliance with the Immigration Reform and Control Act. Contractor is and shall remain an independent contractor and is neither agent, employee, partner, nor joint venturer of County. Contractor acknowledges that it is responsible for complying with the provisions of the Immigration Reform and Control Act of 1986 located at 8 U.S.C. 1324, et seq, and regulations relating thereto, as either may be amended from time to time. Failure to comply with the above provisions shall be considered a material breach of the Agreement.

F. Non-Exclusive Services. This is a non-exclusive Agreement. During the term of this Agreement, and any extensions thereof, the County reserves the right to contract for another provider for similar services as it determines necessary in its sole discretion.

G. Project Monitoring. During the term of the Agreement, Contractor shall cooperate with the County, either directly or through its representatives, in monitoring Contractor's progress and performance of this Agreement.

4. Term of Agreement.

A. Initial Term. The term of this Agreement shall commence on

☐ the Effective Date; or

☒ January 1, 2022, and shall remain in full force and for sixty (60) months, or until termination of the Agreement, whichever occurs first.

B. Term Extension.

The Parties may extend the term of this Agreement for two (2) additional twelve (12) month period(s) pursuant to the same terms, conditions, and pricing set forth in the Agreement by mutually executing an amendment to this Agreement, as provided herein.

5. Compensation and Method of Payment.

A. Services Fee. As total compensation for the Services, the County shall pay the Contractor the sums as provided in this Section 5 ("Services Fee"), pursuant to the terms and conditions as provided in this Agreement. It is acknowledged and agreed by Contractor that this compensation constitutes a limitation upon County's obligation to compensate Contractor for such Services required by this Agreement but does not constitute a limitation upon Contractor's obligation to perform all of the Services required by this Agreement. In no event will the Services Fee paid exceed the not-to-exceed sums set out in subsections 5.B. and C., unless the Parties agree to increase this sum by written amendment as authorized in Section 21 of the Agreement.

B. The County agrees to pay the Contractor the not-to-exceed sum of $9,040,000, not including stop-loss, for Services (inclusive of the ASO Administrative and Network Access fees) completed and accepted as provided in Section 19 herein if applicable, payable on a fixed-fee basis for the deliverables as set out in Exhibit C, payable upon submittal of an invoice as required herein.]

OR (DESCRIBE PAYMENT TERMS)

_____

_____

_____

C. Travel Expenses.

☒ The Services Fee includes all travel, lodging and per diem expenses incurred by Contractor in performing the Services.

☐ The County shall reimburse the Contractor the sum of not-to-exceed $_____ for the travel expenses incurred in accordance with Section 112.061, Florida Statutes, and/or County Travel Policy, and as approved in writing in advance by _____.

D. Taxes. Contractor acknowledges that the County is not subject to any state or federal sales, use, transportation and certain excise taxes.

E. Payments. Contractor shall submit invoices for payments due as provided herein and authorized reimbursable expenses incurred with such documentation as required by County. Invoices shall be submitted to (select appropriate box):

☐ the designated person as set out in Section 18 herein.

☒ as provided in Exhibit D attached hereto.

For time and materials Services, all Contractor Personnel shall maintain logs of time worked, and each invoice shall state the date and number of hours worked for Services authorized to be billed on a time and materials basis. All payments shall be made in accordance with the requirements of Section 218.70 et seq., Florida Statutes, "The Local Government Prompt Payment Act." The County may dispute any payments invoiced by Contractor in accordance with the County's Invoice Payments Dispute Resolution Process established in accordance with Section 218.76, Florida Statutes, and any such disputes shall be resolved in accordance with the County's Dispute Resolution Process.

6. <u>Funding and Payment of Claims.</u>

A. County shall establish a Bank Account, and maintain in the Bank Account an amount sufficient at all times to fund checks written on it for the following (collectively "Bank Account Payments"): (i) Plan Benefits; (ii) those charges and fees identified in the Exhibit C 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 incentive payments to Participating Providers; (b) amounts owed to Contractor; and (c) amounts paid to Contractor's affiliates and/or subcontractors for, among other things, network access or in- and out-of-network health care services/products provided to Members. Contractor may credit the Bank Account with payments due County under a stop loss policy issued by Contractor or an affiliate.

B. Contractor, as agent for the County, shall make Bank Account Payments from the Bank Account, in the amount Contractor 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, Contractor shall cease to process claims for Plan Benefits including Run-Out Claims and notify the County in writing within 30 days so that corrective measures can be taken.

D. Contractor will promptly adjust any underpayment of Plan Benefits by drawing additional funds due the claimant from the Bank Account. In the event Contractor determines that it has overpaid overpays a claim for Plan Benefits or pays 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. Contractor 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, Contractor is expressly authorized by County to take all actions on behalf of the County and/or the Plan to pursue overpayment recovery of Plan Benefits or to collect or recover Pay-for-Performance Recovery including, but not limited to, retaining counsel, settling and compromising claims or Pay-for-Performance Recoveries, in which case Contractor shall be responsible for the attorney fees, court costs or arbitration fees incurred by Contractor 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 Contractor. Contractor shall not be responsible for reimbursing any unrecovered payments of Plan Benefits unless made as a result of its negligence or willful conduct.

E. County shall promptly reimburse Contractor for any Bank Account Payments paid by Contractor with its own funds on County's behalf and no such payment by Contractor shall be construed as an assumption of any of County's liability for such Bank Account Payments.

F. Following termination of this Agreement, County shall remain liable for payment of all Plan Benefits and other due Bank Account Payments and for all reimbursements due Members under the Plan. County shall remain liable for payment of all due Bank Account Payments and for all reimbursements due Members under the Plan. County shall promptly reimburse Connecticut General for any Bank Account Payments paid by Connecticut General with its own and no such payment by Connecticut General shall be construed as an assumption of any of County's liability.

7. Charges

A. Charges. Contractor shall provide to County a monthly statement of all charges County is obligated to pay under this Agreement that are not paid as Bank Account Payments. Payment of all billed charges shall be due on the first day of the month, as indicated on the monthly statement. All payment, invoicing, and dispute resolution shall be in accordance with the Local Government Prompt Payment Act, Fla. Stat. 218.70 et. seq.,and County policy established in conformance therewith.

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. County shall remain responsible for all applicable charges and Bank Account Payments incurred or charged through the date that Contractor processes the retroactive change or termination of membership or 5 days from County's notice thereof, whichever is shorter. However, if the change or termination would result in a reduction in charges, Contractor shall credit to County the reduction in charges charged for the shorter of (a) the sixty (60) day period preceding the date Contractor processes the notice, or (b) the period from the date of the change or termination to the date Contractor processes the notice.

This Section 7 shall survive termination of this Agreement.

8. Personnel.

A. E-Verify. The Contractor and Subcontractor must register with and use the E-verify system in accordance with Florida Statute 448.095. The County will verify the work authorization of the Contractor and Subcontractor. A Contractor and Subcontractor may not enter into a contract with the County unless each party registers with and uses the E-verify system.

If a Contractor enters a contract with a Subcontractor, the Subcontractor must provide the Contractor with an affidavit stating that the Subcontractor does not employ, contract with, or subcontract with unauthorized aliens. The Contractor must maintain a copy of the affidavit for the duration of the contract.

If the County, Contractor, or Subcontract has a good faith belief that a person or entity with which it is contracting has knowingly violated Florida Statute 448.09(1) shall immediately terminate the contract with the person or entity.

If the County has a good faith belief that a Subcontractor knowingly violated this provision, but the Contractor otherwise complied with this provision, the County will notify the Contractor and order that the Contractor immediately terminate the contract with the Subcontractor.

A contract terminated under the provisions of this section is not a breach of contract and may not considered such. Any contract termination under the provisions of this section may be challenged to Section 448.095(2)(d), Florida Statute. Contractor acknowledges upon termination of this agreement by the County for violation of this section by Contractor, Contractor may not be awarded a public contract for at least one (1) year. Contractor acknowledges that Contractor is liable for any additional costs incurred by the County as a result of termination of any contract for a violation of this section.

Contractor or Subcontractor shall insert in any subcontracts the clauses set forth in this section, requiring the subcontracts to include these clauses in any lower tier subcontracts. Contractor shall be responsible for compliance by any Subcontractor or Lower Tier Subcontractor with the clause set for in this section.

B. Qualified Personnel. Contractor agrees that each person performing Services in connection with this Agreement shall have the qualifications and shall fulfill the requirements set forth in this Agreement.

C. Approval and Replacement of Personnel. The County shall have the right to approve all Contractor Personnel specifically assigned to provide the Services to the County, which approval shall not be unreasonably withheld. Prior to commencing the Services, the Contractor shall provide at least ten (10) days written notice of the names and qualifications of the Contractor Personnel assigned to perform Services pursuant to the Agreement. Thereafter, during the term of this Agreement, the Contractor shall promptly and as required by the County provide written notice of the names and qualifications of any additional Contractor Personnel specifically assigned to perform Services for the County. The County, on a reasonable basis, shall have the right to require the removal and replacement of any of the Contractor Personnel performing Services, at any time during the term of the Agreement. The County will notify Contractor in writing in the event the County requires such action. Contractor shall accomplish any such removal within forty-eight (48) hours after receipt of notice from the County and shall promptly replace such person with another person, acceptable to the County, with sufficient knowledge and expertise to perform the Services assigned to such individual in accordance with this Agreement. In situations where individual Contractor Personnel are prohibited by applicable law from providing Services, removal and replacement of such Contractor Personnel shall be immediate and not subject to such forty-eight (48) hour replacement timeframe and the provisions of Section 7. A.1. shall apply if minimum required staffing is not maintained.

9. Termination.

A. Contractor Default Provisions and Remedies of County.

1. Events of Default. Any of the following shall constitute a "Contractor Event of Default" hereunder: (i) Contractor fails to maintain the staffing necessary to perform the Services as required in the Agreement, fails to perform the Services as specified in the Agreement, or fails to complete the Services within the completion dates as specified in the Agreement; (ii) Contractor breaches Section 9 (Confidential Information); (iii) Contractor fails to gain acceptance of a deliverable per Section 15, if applicable, for two (2) consecutive iterations; or (iv) Contractor fails to perform or observe any of the other material provisions of this Agreement.

2. Cure Provisions. Upon the occurrence of a Contractor Event of Default as set out above, the County shall provide written notice of such Contractor Event of Default to Contractor ("Notice to Cure"), and Contractor shall have thirty (30) calendar days after the date of a Notice to Cure to correct, cure, and/or remedy the Contractor Event of Default described in the written notice.

3. Termination for Cause by the County. In the event that Contractor fails to cure a Contractor Event of Default as authorized herein, or upon the occurrence of a Contractor Event of Default as specified in Section 7.A.1. (iii), the County may terminate this Agreement in whole or in part, effective upon receipt by Contractor of written notice of termination pursuant to this provision, and may pursue such remedies at law or in equity as may be available to the County.

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

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

ii. Three (3) business days after Contractor notifies County, in writing, that County has failed to fund the Bank Account as required by this Agreement provided that County has not corrected the funding error. Contractor is not required to provide services during any time that the account is not funded, except to the extent there are funds available in the account to cover such services.

iii. The date which is at least fifteen (15) business days after the date County fails to pay any charges identified in this Agreement when due, provided Contractor notifies County in writing of the failure to pay the charges identified and provides Employer an opportunity to pay the charges within fifteen (15) business days of such notice and Employer fails to pay the charges within such fifteen (15) business day period;

iv. Any other date mutually agreed upon by County and Contractor.

B. County Default Provisions and Remedies of Contractor.

1. Events of Default. Any of the following shall constitute a "County Event of Default" hereunder: (i) the County fails to make timely undisputed payments as described in this Agreement; (ii) the County breaches Section 9 (Confidential Information); or (iii) the County fails to perform any of the other material provisions of this Agreement.

2. Cure Provisions. Upon the occurrence of a County Event of Default as set out above, Contractor shall provide written notice of such County Event of Default to the County ("Notice to Cure"), and the County shall have thirty (30) calendar days after the date of a Notice to Cure to correct, cure, and/or remedy the County Event of Default described in the written notice.

3. Termination for Cause by Contractor. In the event the County fails to cure a County Event of Default as authorized herein, Contractor may terminate this Agreement in whole or in part effective on receipt by the County of written notice of termination pursuant to this provision, and may pursue such remedies at law or in equity as may be available to the Contractor. In the event of termination, any claims payments or administrative fees due and owing for up to the effective date of termination of this Agreement, including any mutually-agreed run out period, will be paid in accordance with Section 5(a).

C. Termination for Convenience. Notwithstanding any other provision herein, the County may terminate this Agreement, without cause, by giving thirty (30) days advance written notice to the Contractor of its election to terminate this Agreement pursuant to this provision.

10. Time is of the Essence. Time is of the essence with respect to all provisions of this Agreement that specify a time for performance, including the Services as described in Exhibits attached hereto; provided, however, that the foregoing shall not be construed to limit a Party's cure period allowed in the Agreement.

11. Confidential Information and Public Records.

A. County Confidential Information. Contractor shall not disclose to any third party County Confidential Information that Contractor, through its Contractor Personnel, has access to or has received from the County pursuant to its performance of Services pursuant to the Agreement, unless approved in writing by the County Contract Manager. All such County Confidential Information will be held in trust and confidence from the date of disclosure by the County, and discussions involving such County Confidential Information shall be limited to Contractor Personnel as is necessary to complete the Services.

B. Contractor Confidential Information. All Contractor Confidential Information received by the County from Contractor will be held in trust and confidence from the date of disclosure by Contractor and discussions involving such Contractor Confidential Information shall be limited to the members of the County's staff and the County's subcontractors who require such information in the performance of this Agreement. The County acknowledges and agrees to respect the copyrights, registrations, trade secrets and other proprietary rights of Contractor in the Contractor Confidential Information during and after the term of the Agreement and shall at all times maintain the confidentiality of the Contractor Confidential Information provided to the County, subject to federal law and the laws of the State of Florida related to public records disclosure. Contractor shall be solely responsible for taking any and all action it deems necessary to protect its Contractor Confidential Information except as provided herein. Contractor acknowledges that the County is subject to public records legislation, including but not limited to Chapter 119, Florida Statutes, and the Florida Rules of Judicial Administration, and that any of the County's obligations under this Section may be superseded by its obligations under any requirements of said laws.

C. Public Records. Contractor acknowledges that information and data it manages as part of the services may be public records in accordance with Chapter 119, Florida Statutes and Pinellas County public records policies. Contractor agrees that prior to providing services it will implement policies and procedures to maintain, produce, secure, and retain public records in accordance with applicable laws, regulations, and County policies, including but not limited to the Section 119.0701, Florida Statutes. Notwithstanding any other provision of this Agreement relating to compensation, the Contractor agrees to charge the County, and/or any third parties requesting public records only such fees allowed by Section 119.07, Florida Statutes, and County policy for locating and producing public records during the term of this Agreement.

If the Contractor has questions regarding the application of Chapter 119, Florida Statutes, to the Contractor's duty to provide public records relating to this contract, contact the Pinellas County Board of County Commissioners, Purchasing and Risk Management Department, Operations Manager custodian of public records at 727-464-3311, purchase@pinellascounty.org, Pinellas County Government, Purchasing and Risk Management Department, Operations Manager, 400 S. Ft. Harrison Ave, 6th Floor, Clearwater, FL 33756.

12. Audit. Contractor shall retain all records relating to this Agreement for a period of at least five (5) years after final payment is made. All records shall be kept in such a way as will permit their inspection pursuant to Chapter 119, Florida Statutes. In addition, County reserves the right to examine and/or audit such records. Audits of claims individually payable by County (e.g. self-funded claim reviews) shall be conducted upon the mutual agreement of appropriate audit scope and terms, and subject to mutually-executed audit and non-disclosure agreements as set forth in the Administrative Services Agreement attached.

A. Claim Audits

a. Claim Audit. County may, audit Contractor's payment of Plan Benefits in accordance with the following requirements:

i. County shall provide to Contractor a scope of audit letter and the fully executed Claim Audit Agreement, a sample of which is attached hereto as Attachment 4 together with a forty-five (45) day advance written request for audit.

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

iii. County and Contractor will agree upon the date for the audit during regular business hours in a virtual/remote audit environment or at Contractor'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 Contractor's Claim Audit Agreement attached hereto as Attachment 4, which is hereby agreed to by County 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.

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

While this Agreement is in effect there shall be no additional cost to County for an audit of payment documents (relating to a random, statistically valid sample of two hundred seventy five (275) claims paid during the two prior Plan years and not previously audited, County may conduct one such audit every Plan Year (but not within six (6) months of a prior audit). In no event shall any audit involve Plan benefit

payments made prior to the most recent two (2) Plan Years. In the event Employer requests to alter the scope of the claim audit, Contractor will endeavor to reasonably accommodate the County's request, which may be subject to additional charges to be mutually agreed upon by the County and Contractor prior to the start of the audit. Charges for audits beyond this scope shall be agreed to by County and Contractor in writing prior to 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 seventy-five (275) claims paid.
    - Requests to review provider contracts will be subject to CHLIC's current criteria and permissions.
- **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.
- **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.

Charges for audits beyond this scope shall be agreed to by County and Contractor in writing prior to the audit.

13. Compliance with Laws.

Contractor shall comply with all applicable federal, state, county and local laws, ordinances, rules and regulations in the performance of its obligations under this Agreement, including the procurement of permits and certificates where required, and including but not limited to laws related to Workers Compensation, Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, Minority Business Enterprise (MBE), occupational safety and health and the environment, equal employment opportunity, privacy of medical records and information, as applicable. Failure to comply with any of the above provisions shall be considered a material breach of the Agreement.

14. Digital Accessibility

Suppler acknowledges and warrants that all digital content and services provided under this contract substantially conforms and shall continue to substantially conform during the Term of this Agreement to the W3C Web Content Accessibility Guidelines, version 2.0 or higher ("WCAG 2.0") at conformance Level A and AA.

If during the Term of this Agreement, Supplier fails to maintain compliance with WCAG 2.0 A and AA or Pinellas County otherwise identifies an issue related to accessibility of the product (the "Accessibility Issue") that renders the product inaccessible, then Pinellas County shall notify Supplier of non-compliance. Within 30 days of Supplier's receipt of a non-compliance notice ("Notice"), Supplier and Pinellas County shall meet and mutually agree upon an appropriate timeline for resolution of the Accessibility Issue(s) ("Initial Meeting").

Should Supplier:

i. fail to acknowledge receipt of the notice within 30 days of receipt of the Notice;
ii. unreasonably and solely withhold agreement regarding a timeline for resolution for more than 30 days following the Initial Meeting; or
iii. fail to materially resolve the Accessibility Issue(s) within the agreed-upon timeline,

Failure to comply with the requirements of this section shall constitute a material breach of this Agreement and shall be grounds for termination of this Agreement by Pinellas County.

15. Public Entities Crimes

Contractor is directed to the Florida Public Entities Crime Act, Section 287.133, Florida Statutes, as well as Florida Statute 287.135 regarding Scrutinized Companies, and represents to County that Contractor is qualified to transact business with public entities in Florida, and to enter into and fully perform this Agreement subject to the provisions state therein. Failure to comply with any of the above provisions shall be considered a material breach of the Agreement.

16. Liability and Insurance.

A. Insurance. Contractor shall comply with the insurance requirements set out in Exhibit B, attached hereto and incorporated herein by reference.

17. Plan Benefit Liability

A. County Liability for Plan Benefits. County is solely responsible for all Plan Benefits including any Plan Benefits paid as a result of any legal action. If Employer directs Contractor in writing to pay Extra-Contractual Benefits, County is responsible for funding the payment and such payments shall not be considered in determining reimbursements or payments under stop loss insurance provided by Contractor or Contractor affiliate or in determining any Contractor or Contractor affiliate risk-sharing or performance guarantee reimbursements.

B. County Liability for Plan-Related Expenses. County shall reimburse Contractor for any amounts Contractor may be required to pay (i) as state premium tax or any similar Plan-related tax, charge, surcharge or assessment assessed specifically against the County's plan, or (ii) under any unclaimed or abandoned property, or escheat law, with respect to Plan Benefits and any penalties and/or interest thereonCosts related to affirmative litigation pursued without prior written County consent and prior approval/agreement of costs will remain the responsibility of Contractor.

C. Alternative Litigation Management Option. At County's election and until and unless changed, and contingent upon timely payment by County of the associated additional "Claim Litigation Charge" (which is included in the medical administrative fee) set forth in the Schedule of Financial Charges, County may elect to have Contractor assume responsibility for the management of any legal actions with respect to disputed claims for Plan benefits and bear the legal expenses associated with defending such action so long as Contractor processed the claim(s) in dispute. This option does not extend to actions against County and/or Contractor 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). County shall remain responsible for payment of any benefits determined to be payable under the Plan as a result of a legal action and any damages or penalties assessed in connection with such legal action however, County shall not be liable for any sanctions or penalties that might be assessed against Contractor's legal counsel.

D. The reimbursement obligations set forth in this Section 16 shall survive termination of this Agreement

E. **Indemnification.** Contractor agrees to indemnify, pay the cost of defense, including attorney's fees, and hold harmless the County, its officers, employees and agents from all non-Plan Benefit damages, suits, actions or claims, including reasonable attorney's fees incurred by the County, of any character brought on account of any injuries or damages received or sustained by any person, persons, or property, or in any way relating to or arising from negligence of Contractor in the performance of Services under the Agreement; or on account of negligent any act or omission, neglect or misconduct of Contractor; or by, or on account of, any claim or amounts recovered under the Workers' Compensation Law or of any other laws, regulations, ordinance, order or decree; or arising from or by reason of any actual or claimed trademark, patent or copyright infringement or litigation based thereon; except only such injury or damage as shall have been occasioned by the sole or contributory negligence of the County. County retains responsibility for the payment of any valid claims to the extent otherwise payable by the County in the absence of such legal actions or claims (e.g. self-funded claims). Contractor retains responsibility for the payment of valid claims otherwise payable by Contractor in the absence of such legal action or claims (e.g. fully-insured), and, notwithstanding the foregoing, will indemnify only in the event, and to the extent, it has negligently failed to process valid fully-insured claims when due.

F. **Liability.** Neither the County nor Contractor shall make any express or implied agreements, guaranties or representations, or incur any debt, in the name of or on behalf of the other Party. Neither the County nor Contractor shall be obligated by or have any liability under any agreements or representations made by the other that are not expressly authorized hereunder. The County shall have no liability or obligation for any damages to any person or property directly or indirectly arising out of the operation by Contractor of its business, whether caused by Contractor's negligence or willful action or failure to act.

G. **Contractor's Taxes.** The County will have no liability for any sales, service, value added, use, excise, gross receipts, property, workers' compensation, unemployment compensation, withholding or other taxes, whether levied upon Contractor or Contractor's assets, or upon the County in connection with Services performed or business conducted by Contractor. Payment of all such taxes and liabilities shall be the responsibility of Contractor.

18. County's Funding. The Agreement is not a general obligation of the County. It is understood that neither this Agreement nor any representation by any County employee or officer creates any obligation to appropriate or make monies available for the purpose of the Agreement beyond the fiscal year in which this Agreement is executed. No liability shall be incurred by the County, or any department, beyond the monies budgeted and available for this purpose. If funds are not appropriated by the County for any or all of this Agreement, the County shall not be obligated to pay any sums provided pursuant to this Agreement beyond the portion for which funds are appropriated. The County agrees to promptly notify Contractor in writing of such failure of appropriation, and upon receipt of such notice, this Agreement, and all rights and obligations contained herein, shall terminate without liability or penalty to the County.

19. Acceptance of Services. For all Services deliverables that require County acceptance as provided in the Statement of Work, the County, through the Director of Human Resources or designee, will have ten (10) calendar days to review the deliverable(s) after receipt or completion of same by Contractor, and either accept or reject the deliverable(s) by written notice to Cigna Health and Life Insurance Company (CHLIC) and Cigna Behavioral Health, Inc. If a deliverable is rejected, the written notice from the County will specify any required changes, deficiencies, and/or additions necessary. Contractor shall then have seven (7) calendar days to revise the deliverable(s) to resubmit and/or complete the deliverable(s) for review and approval by the County, who will then have seven (7) calendar days to review and approve, or reject the deliverable(s); provided however, that Contractor shall not be responsible for any delays in the overall project schedule that result from the County's failure to timely approve or reject

deliverable(s) as provided herein. Upon final acceptance of the deliverable(s), the County will accept the deliverable(s) in writing.

20. Subcontracting/Assignment.

A. Subcontracting. Contractor is fully responsible for completion of the Services required by this Agreement and for completion of all subcontractor work, if authorized as provided herein. Contractor shall not subcontract any work which is exclusively for the benefit of County, without the prior written consent of the County, which shall be determined by the County in its sole discretion.

B. Assignment.

☐ This Agreement, and any rights or obligations hereunder, shall not be assigned, transferred or delegated to any other person or entity. Any purported assignment in violation of this section shall be null and void.

☒ This Agreement, and all rights or obligations hereunder, shall not be assigned, transferred, or delegated in whole or in part, including by acquisition of assets, merger, consolidation, dissolution, operation of law, change in effective control of the Contractor, or any other assignment, transfer, or delegation of rights or obligations, without the prior written consent of the County, unless such assignment is to an affiliate or subsidiary of Contractor. The Contractor shall provide written notice to the County within fifteen (15) calendar days of any action or occurrence assigning the Agreement or any rights or obligations hereunder as described in this section, unless such assignment is to an affiliate or subsidiary of Contractor. In the event the County does not consent to an assignment requiring consent, as determined in its sole discretion, the purported assignment in violation of this section shall be null and void, and the County may elect to terminate this Agreement by providing written notice of its election to terminate pursuant to this provision upon fifteen (15) days' notice to Contractor. Should such assignment be to an affiliate or subsidiary of Contractor, Contractor shall remain liable to the same extent as if Contractor had performed the services itself.

21. Survival. The following provisions shall survive the expiration or termination of the Term of this Agreement: 7, 9, 10, 13 20, 23, and any other which by their nature would survive termination.

22. Notices. All notices, authorizations, and requests in connection with this Agreement shall be deemed given on the day they are: (1) deposited in the U.S. mail, postage prepaid, certified or registered, return receipt requested; or (2) sent by air express courier (e.g., Federal Express, Airborne, etc.), charges prepaid, return receipt requested; or (iii) sent via email and addressed as set forth below, which designated person(s) may be amended by either Party by giving written notice to the other Party:

For County:

Attn: Kimberly Crum, Director of Human Resources
Pinellas County Human Resources
400 South Fort Harrison Avenue
Clearwater, FL 33756

with a copy to:
Merry Celeste
Purchasing Division Director
Pinellas County Purchasing Department
400 South Fort Harrison Avenue
Clearwater, FL 33756

For Contractor:

Attn: Mr. Morris Dean Mirabella, Vice President
of CHLIC and Authorized Signatory
900 Cottage Grove Road
Hartford, CT 06152

23. Conflict of Interest.

A. The Contractor represents that it presently has no interest and shall acquire no interest, either direct or indirect, which would conflict in any manner with the performance of the Services required hereunder, and

that no person having any such interest shall be employed by Contractor during the agreement term and any extensions; and during the term of this Agreement.

B. The Contractor shall promptly notify the County in writing of any business association, interest, or other circumstance which constitutes a conflict of interest as provided herein. If the Contractor is in doubt as to whether a prospective business association, interest, or other circumstance constitutes a conflict of interest, the Contract may identify the prospective business association, interest or circumstance, the nature of work that the Contractor may undertake and request an opinion as to whether the business association, interest or circumstance constitutes a conflict of interest if entered into by the Contractor. The County agrees to notify the Contractor of its opinion within (10) calendar days of receipt of notification by the Contractor, which shall be binding on the Contractor.

24. Right to Ownership. All work created, originated and/or prepared by Contractor in performing Services pursuant to the Agreement, specifically for the County, and other documentation or improvements related thereto, to the extent that such work, products, documentation, materials or information are described in or required by the Services (collectively, the "Work Product") shall be County's property when completed and accepted, if acceptance is required in this Agreement, and the County has made payment of the sums due therefore. The ideas, concepts, know-how or techniques developed during the course of this Agreement by the Contractor or jointly by Contractor and the County may be used by the County without obligation of notice or accounting to the Contractor. Any data, information or other materials furnished by the County for use by Contractor under this Agreement shall remain the sole property of the County.

25. Amendment. This Agreement may be amended by mutual written agreement of the Parties hereto.

A. Modification of Agreement

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 or other financial terms, including any terms or conditions related thereto, 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 25B by Contractor providing written notice to County and County indicating its acceptance of the modification either by paying the revised charges or failing to object to such revised charges in writing to Contractor within fifteen (15) business days of receipt of such notice from Contractor. The revised charges will be effective on the date indicated in Contractor's written notice to County unless otherwise agreed to by Contractor and County.

B. Modification of Plan and Charges

a. Except as may be otherwise provided in the Schedule of Financial Charges, Contractor shall have the right to revise the charges identified in this Agreement (i) upon mutual written agreement after any significant modification or amendment of the benefits under the Plan that significantly impacts the services required by Contractor, (ii) upon the number of members decreasing by fifteen percent (15%) to twenty-five (25%), the Medical Administration Charges and Medical Network Access Fee will increase up to 20% and/or a number of onsite services/staff will be removed. If the number of members decreases more than 25%, the Contractor will re-calculate its charges and work with the County before being billed the new premium; and/or (iii) upon mutual written agreement to account for a significant change in law or regulation that materially impacts Contractor's s liabilities and/or responsibilities under this Agreement.

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

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

26. Severability. The terms and conditions of this Agreement shall be deemed to be severable. Consequently, if any clause, term, or condition hereof shall be held to be illegal or void, such determination shall not affect the validity or legality of the remaining terms and conditions, and notwithstanding any such determination, this Agreement shall continue in full force and effect unless the particular clause, term, or condition held to be illegal or void renders the balance of the Agreement impossible to perform.

27. Applicable Law and Venue. This Agreement shall be governed by and construed in accordance with the laws of the State of Florida (without regard to principles of conflicts of laws). The Parties agree that all actions or proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state or federal (if permitted by law and a Party elects to file an action in federal court) courts located in or for Pinellas County, Florida. This choice of venue is intended by the Parties to be mandatory and not permissive in nature, and to preclude the possibility of litigation between the Parties with respect to, or arising out of, this Agreement in any jurisdiction other than that specified in this section. Each Party waives any right it may have to assert the doctrine of *forum non conveniens* or similar doctrine or to object to venue with respect to any proceeding brought in accordance with this section.

28. Choice of Law

This Agreement shall be interpreted and construed in accordance with the laws of the State of Florida. Any and all claims, controversies, and causes of action arising out of or relating to this Agreement, whether sounding in contract, tort, or statute, shall be governed by the laws of the State of Florida, including its statutes of limitations, without regard to any conflict-of-laws or other rule that would result in the application of the law of a different jurisdiction.

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

28. Resolution of Disputes

Any dispute between the Parties arising from or relating to the performance or interpretation of this Agreement ("Controversy") shall be resolved pursuant to the following 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 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. Once such attempt is made, either party may pursue other remedies available.

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

30 Due Authority. Each Party to this Agreement represents and warrants that: (i) it has the full right and authority and has obtained all necessary approvals to enter into this Agreement; (ii) each person executing this Agreement on behalf of the Party is authorized to do so; (iii) this Agreement constitutes a valid and legally binding obligation of the Party, enforceable in accordance with its terms.

31 No Third Party Beneficiary. The Parties hereto acknowledge and agree that there are no third party beneficiaries to this Agreement. Persons or entities not a party to this Agreement may not claim any benefit from this Agreement or as third party beneficiaries hereto.

32 Entire Agreement. This Agreement constitutes the entire Agreement between the Parties and supersedes all prior negotiations, representations or agreements either oral or written.

33 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, 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 33 shall survive termination of this Agreement

34 Independent Contractors

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

35 Reservation of Intellectual Property Rights

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

36. 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.

(Signature Page Follows)

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement the day and year first written.

PINELLAS COUNTY, FLORIDA
By and through its

Board of County Commissioners

By

ATTEST:
Ken Burke,
Clerk of the Circuit Court

By:
Deputy Clerk

Approved as to Form

By: Carole Sanzeri
Office of the County Attorney

Cigna Health and Life Insurance Company (CHLIC) and Cigna Behavioral Health, Inc
Name of Firm

By: Victoria A Sirica
Signature

Victoria A Sirica
Print Name

Operations Sr. Manager
Title

The terms and scope of Services to be provided by Contractor to the County shall be governed by the Agreement and the following Statement of Work:

1. The Statement of Work Exhibit A and Attachments.

As indicated in the Agreement 25.B.d., County is solely responsible for communicating any Plan modification or amendment to Members or individuals considering enrolling in the Plan.

2. The Stop Loss Application and Policy.

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

CLAIM ADMINISTRATION		
Products excluding Health Savings Account		
	Calculate benefits, check and/or electronic payments disbursed from Employer's Bank Account. Bank Account payments will appear in Employer's standard Bank Account activity data reports.	**All Products**
	CHLIC's generic claim forms are made available to Employer for individuals eligible to enroll in the Plan.	**All Products**
	CHLIC's Special Investigations Unit will investigate, pend, recommend denial of claims in whole or in part, and/or reprocess claims, as appropriate.	**All Products**
	Discuss claims, when appropriate, with providers of health services.	**All Products**
	Perform, based on CHLIC's book of business internal audits of plan benefit payments on a random sample basis.	**All Products**
	Claim control procedures reported annually in Statement on Standards for Attestation Engagements (SSAE) No. 18 Report (or any applicable successor thereto).	**All Products**
	Respond to Insurance Department complaints.	**All Products**
	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Products**
	Member Explanation of Benefit ("**EOB**") statements including, when applicable, notice of denied claims, denial reason(s) and appeal rights.	**All Products (excluding Pharmacy)**
	Verify enrollment and eligibility using Member information submitted by Employer and/or its authorized agent.	**All Products**
Medical Only		
	CHLIC's generic enrollment form is made available to Employer for individuals eligible to enroll in the Plan.	**All Medical Products**
	CHLIC's standard ID card with toll-free telephone number are prepared and mailed directly to Members.	**All Medical Products**
	Administration of subrogation/conditional Claim Payment (terms described in Attachment 5).	**All Medical Products**
HEALTH SAVINGS ACCOUNT		
Administration		
	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	**HSA Product**

	Statements that reflect account activity. CHLIC shall provide to Employer its standard reports of aggregate non-identifiable information concerning the administration of the HSA.	
	Claim Forwarding: Each HSA Account Holder may elect to have claims not payable under the HDHP paid from funds in the Account Holder's HSA, to the extent that funds are available in such account ("**Claim Forwarding**"), whether or not the expense is a qualified IRS medical expense. Claim Forwarding is only available for payments due medical providers. Claim Forwarding is not available for pharmacy expenses.	**HSA Product**
	Use of HSA: HSA Account Holders are solely responsible to use HSA funds as permitted by law, including Section 223(a) of the Internal Revenue Code, to qualify for applicable tax benefits.	**HSA Product**
	Enrollment in High Deductible Health Plan - 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**
	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**
	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) perform manual funding of Employee bank accounts; 3) download various reports; 4) learn of upcoming changes in HSA rules; 5) use the links and tools for HSA education and additional information.	**HSA Product**
	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		

	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**
	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**
	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		
	Employee Agreement with Bank – Eligible Employees wishing to enroll in an HSA may be required to execute certain bank documents including a custodial agreement. Approved eligible Employees will become Account Holders and contract directly with the Bank Vendor for the establishment and maintenance of the HSA, including the issuance of debit cards and checks.	**HSA Product**
	Investment of Account Funds – While Bank Vendor offers various investment options in connection with the funds in the HSA, the HSA Account Holder is solely responsible for selecting and approving the investment vehicles into which their HSA funds will be invested. HSA Account Holders exercise sole investment discretion over their HSA investments.	**HSA Product**
	Bank Fees – CHLIC pays Bank Vendor to administer the HSA Accounts.	**HSA Product**
	Bank Fees to Accountholder – It is understood that there are separate account fees charged each HSA Account Holder by the Bank Vendor pursuant to terms communicated to HSA Account Holders through separate bank documents.	**HSA Product**
Termination		
	Termination of HSA Account Holder's HDHP or of Services Under This Exhibit – Free Agents: In the event of the termination of an HSA Account Holder's HDHP coverage through 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	**HSA Product**

	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.	
	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**
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		
	5500 Schedule C reporting.	**All Products**
	5500 Schedule A or Annual Reconciliation Disclosure reporting (when applicable)	**All Products**
	CHLIC's standard Underwriting services: a) benefit design analysis b) projected cost analysis.	**All Products**
HIPAA INDIVIDUAL RIGHTS		
Products excluding Health Savings Account		
	Handling of requests from Members for access to, amendment and accounting of protected health information, and requests for restrictions and alternative communications as required under federal HIPAA law and regulations, as set out in this Agreement and its Exhibits.	**All Products**
COST CONTAINMENT		
	Maximum reimbursable charge determinations of non-Participating Provider charges for covered services.	**All Medical Products (with out-of-network benefits)**
	CHLIC's standard cost containment controls: Application of non-duplication and coordination of benefits rules and coordination with Medicare.	**All Medical Products**

	Delivery of information, as necessary, regarding standard application of non-duplication or coordination of benefits.	**All Medical Products**
	Review of medical bills in accordance with CHLIC's then current Medical Bill Review program.	**All Medical Products**
	Network Savings Program, a national vendor network that provides discounted rates when a Member accesses care through a Network Savings Program contracted provider.	**All Medical Products**
	Annual reporting of CHLIC's standard cost containment results upon Employer's request.	**All Medical Products**
CUSTOMER REPORTING		
	Summary reports of medical cost and utilization experience (where applicable), upon completion of internal report generation, are available through Cigna's web site, CignaAccess.com.	**All Medical Products**
	Claim Reporting: CHLIC will provide standard banking and financial report information based upon paid claim data. CHLIC will not provide information on incurred-but-not reported claims, projected claims, pre-certifications of coverage, case management information or information on a Member's prognosis or course of treatment.	**All Medical Products**
	Stop Loss Reporting is an optional service provided at an additional fee to Employers who have stop loss through another entity other than CHLIC. CHLIC will provide its standard reporting only after the stop loss carrier and Employer have executed CHLIC's standard Hold Harmless/Confidentiality Agreement.	**All Medical Products**
	CHLIC's standard Individual Summary Statements for applicable participating Members.	**HSA Products**
MEMBER EXTERNAL REVIEW PROGRAM		
	CHLIC contracts with a minimum of three (3) independent review organizations that meet the Patient Protection and Affordable Care Act (PPACA) external review requirements. Members may appeal eligible claims requiring medical judgment to an external independent review organization which is selected by CHLIC on a random basis. If Employer has chosen not to participate in this program, the Employer may be responsible for making other arrangements to meet the Patient Protection and Affordable Care Act (PPACA) external review requirements.	**All Medical Products**
MEDICAL MANAGEMENT SERVICES		
	CHLIC provides integrated medical management that includes (depending upon the terms of the Plan) the following core services.	
	Pre-Admission Certification and Continued Stay Review (PAC/CSR) services to certify coverage of acute and sub-acute inpatient admissions/stays or provides guidance to appropriate alternative settings. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products**

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

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

BEHAVIORAL HEALTH		
	CHLIC has contracted with an affiliate, 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** **and OAP Products**
CIGNA STAFF MODEL HEALTHPLAN SERVICES		
	The Cigna HealthCare of Arizona, Inc. staff model ("**Cigna Medical Group**" or "**CMG**") is a multispecialty participating provider group located in metropolitan Phoenix, Arizona. CMG's integrated care delivery model and population health management team work together to facilitate the way in which patients and doctors communicate and interact in order to increase patient satisfaction and improve health outcomes. Plan Participants may at some time receive treatment from a CMG facility or provider even if they do not reside in Arizona (as when traveling). Plan Participants utilizing Cigna participating provider networks in Arizona may access certain specialty and/or ancillary services (such as imaging and urgent care services) through the CMG system. For covered services provided to Participants, CMG is paid at the rates in effect at the time of service (as may be revised from time to time). Representative rates for routinely performed services are attached to the Schedule of Financial Charges herein. A complete copy of the rates is available on request under a mutually agreed nondisclosure agreement ("**NDA**"). 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	**All Medical Products**

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

EXHIBIT A

STATEMENT OF WORK

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

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

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

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

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

CMG pharmacy rates:

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

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

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

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

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

EXHIBIT B

INSURANCE REQUIREMENTS

1. LIMITATIONS ON LIABILITY. Proposer acknowledges and agrees that the services will be provided without any limitation on Proposer's liability. The County objects to and shall not be bound by any term or provision that purports to limit the Proposer's liability to any specified amount in the performance of the services. Proposer shall state any exceptions to this provision in its response, including specifying the proposed limits of liability in the stated exception to be included in the Services Agreement. Proposer is deemed to have accepted and agreed to provide the services without any limitation on Proposer's liability that Proposer does not take exception to in its response. Notwithstanding any exceptions by Proposer, the County reserves the right to declare its prohibition on any limitation on Proposer's liability as non-negotiable, to disqualify any Proposal that includes exceptions to this prohibition on any limitation on Proposer's liability, and to proceed with another responsive, responsible proposal, as determined by the County in its sole discretion.

2. INDEMNIFICATION. Proposer acknowledges and agrees to be bound by and subject to the County's indemnification provisions as set out in the Services Agreement. The County objects to and shall not be bound by any term or provision that purports to modify or amend the Proposer's indemnification obligations in the Services Agreement, or requires the County to indemnify and/or hold the Proposer harmless in any way related to the services. Proposer shall state any exceptions to this provision in the response, including specifying the proposed revisions to the Services Agreement indemnification provisions, or the proposed indemnification from the County to the Proposer to be included in the Services Agreement. Proposer is deemed to have accepted and agreed to provide the services subject to the Services Agreement indemnification provisions that Proposer does not take exception to in its response. Notwithstanding any exceptions by Proposer, the County reserves the right to declare its indemnification requirements as non-negotiable, to disqualify any Proposal that includes exceptions to this paragraph, and to proceed with another responsive, responsible proposal, as determined by the County in its sole discretion.

3. INSURANCE:

   Proposer must provide a certificate of insurance and endorsement in accordance with the insurance requirements listed below, prior to award of contract. Failure to provide the required insurance within the requested timeframe may result in your submittal being deemed non-responsive.

   The contracted Proposer shall obtain and maintain, and require any sub-contractors to obtain and maintain, at all times during its performance of the Agreement, insurance of the types and in the amounts set forth. For projects with a Completed Operations exposure, Contractor shall maintain coverage and provide evidence of insurance for two (2) years beyond final acceptance. All insurance policies shall be from responsible companies duly authorized to do business in the State of Florida and have an AM Best rating of A- VIII or better.

   a) Proposal submittals should include, the Proposer's current Certificate(s) of Insurance in accordance with the insurance requirements listed below. If Proposer does not currently meet insurance requirements, Proposer shall also include verification from their broker or agent that any required insurance not provided at that time of submittal will be in place prior to the award of contract.

   b) Proposer shall email certificate that is compliant with the insurance requirements to Lucy Nowacki at **Lnowacki@pinellascounty.org** .If certificate received with bid was a compliant certificate no further action may be necessary. The Certificate(s) of Insurance shall be signed by authorized representatives of the insurance companies shown on the Certificate(s). **A copy of the endorsement(s) referenced in paragraph d) for Additional Insured shall be attached to the certificate(s) referenced in this paragraph.** The certificate must name Pinellas County, a Political Subdivision of the State of Florida **400 S fort Harrison Avenue Clearwater, FL 33756**, as certificate holder. Certificate marked "Sample", or blank certificate holder information are not compliant.

c) Approval by the County of any Certificate(s) of Insurance does not constitute verification by the County that the insurance requirements have been satisfied or that the insurance policy shown on the Certificate(s) of Insurance is in compliance with the requirements of the Agreement. County reserves the right to require a certified copy of the entire insurance policy, including endorsement(s), at any time during the RFP and/or contract period.

d) All policies providing liability coverage(s), other than professional liability and workers compensation policies, obtained by the Proposer and any subcontractors to meet the requirements of the Agreement shall be endorsed to include **Pinellas County a Political subdivision of the State of Florida** as an Additional Insured.

e) If any insurance provided pursuant to the Agreement expires or cancels prior to the completion of the Work, you will be notified by CTrax, the authorized vendor of Pinellas County. Upon notification, renewal Certificate(s) of Insurance and endorsement(s) shall be furnished to Pinellas County Risk Management at InsuranceCerts@pinellascounty.org and to CTrax c/o JDi Data at PinellasSupport@idata.com by the Proposer or their agent prior to the expiration date.,

(1) Proposer shall also notify County within twenty-four (24) hours after receipt, of any notices of expiration, cancellation, nonrenewal or adverse material change in coverage received by said Proposer from its insurer. Notice shall be given by email to Pinellas County Risk Management at InsuranceCerts@pinellascounty.org. Nothing contained herein shall absolve Proposer of this requirement to provide notice.

(2) Should the Proposer, at any time, not maintain the insurance coverages required herein, the County may terminate the Agreement, or at its sole discretion may purchase such coverages necessary for the protection of the County and charge the Proposer for such purchase or offset the cost against amounts due to proposer for services completed. The County shall be under no obligation to purchase such insurance, nor shall it be responsible for the coverages purchased or the insurance company or companies used. The decision of the County to purchase such insurance shall in no way be construed to be a waiver of any of its rights under the Agreement.

f) The County reserves the right, but not the duty, to review and request a copy of the Contractor's most recent annual report or audited financial statement when a self-insured retention (SIR) or deductible exceeds $50,000.

g) If subcontracting is allowed under this RFP, the Prime Proposer shall obtain and maintain, at all times during its performance of the Agreement, insurance of the types and in the amounts set forth; and require any subcontractors to obtain and maintain, at all times during its performance of the Agreement, insurance limits as it may apply to the portion of the Work performed by the subcontractor; *but in no event will the insurance limits be less than $500,000 for Workers' Compensation/Employers' Liability, and $1,000,000 for General Liability and Auto Liability if required below.*

(1) All subcontracts between Proposer and its subcontractors shall be in writing and are subject to the County's prior written approval. Further, all subcontracts shall (1) require each subcontractor to be bound to Proposer to the same extent Proposer is bound to the County by the terms of the Contract Documents, as those terms may apply to the portion of the Work to be performed by the subcontractor; (2) provide for the assignment of the subcontracts from Proposer to the County at the election of Owner upon termination of the Contract; (3) provide that County will be an additional indemnified party of the subcontract; (4) provide that the County will be an additional insured on all insurance policies required to be provided by the subcontractor except workers compensation and professional liability; (5) provide waiver of subrogation in favor of the County and other insurance terms and/or conditions as outlined below; (6) assign all warranties directly to the County; and (7) identify the County as an

intended third-party beneficiary of the subcontract. Proposer shall make available to each proposed subcontractor, prior to the execution of the subcontract, copies of the Contract Documents to which the subcontractor will be bound by this Section C and identify to the subcontractor any terms and conditions of the proposed subcontract which may be at variance with the Contract Documents.

h) Each insurance policy and/or certificate shall include the following terms and/or conditions:

(1) The Named Insured on the Certificate of Insurance and insurance policy must match the entity's name that responded to the solicitation and/or is signing the agreement with the County. If Proposer is a Joint Venture per Section A. titled Joint Venture of this RFP, Certificate of Insurance and Named Insured must show Joint Venture Legal Entity name and the Joint Venture must comply with the requirements of Section C with regard to limits, terms and conditions, including completed operations coverage.

(2) Companies issuing the insurance policy, or policies, shall have no recourse against County for payment of premiums or assessments for any deductibles which all are at the sole responsibility and risk of Contractor.

(3) The term "County" or "Pinellas County" shall include all Authorities, Boards, Bureaus, Commissions, Divisions, Departments and Constitutional offices of County and individual members, employees thereof in their official capacities, and/or while acting on behalf of Pinellas County.

(4) The policy clause "Other Insurance" shall not apply to any insurance coverage currently held by County or any such future coverage, or to County's Self-Insured Retentions of whatever nature.

(5) All policies shall be written on a primary, non-contributory basis.

(6) Any Certificate(s) of Insurance evidencing coverage provided by a leasing company for either workers compensation or commercial general liability shall have a list of covered employees certified by the leasing company attached to the Certificate(s) of Insurance. The County shall have the right, but not the obligation to determine that the Proposer is only using employees named on such list to perform work for the County. Should employees not named be utilized by Proposer, the County, at its option may stop work without penalty to the County until proof of coverage or removal of the employee by the contractor occurs, or alternatively find the Proposer to be in default and take such other protective measures as necessary.

(7) Insurance policies, other than Professional Liability, shall include waivers of subrogation in favor of Pinellas County from both the Proposer and subcontractor(s).

i) The minimum insurance requirements and limits for this Agreement, which shall remain in effect throughout its duration and for two (2) years beyond final acceptance for projects with a Completed Operations exposure, are as follows:

(1) Workers' Compensation Insurance

Limit	Florida Statutory
Employers' Liability Limits	
Per Employee	$ 500,000
Per Employee Disease	$ 500,000
Policy Limit Disease	$ 500,000

EXHIBIT B

INSURANCE REQUIREMENTS

(2) Commercial General Liability Insurance including, but not limited to, Independent Contractor, Contractual Liability Premises/Operations, Products/Completed Operations, and Personal Injury.

Limits

Combined Single Limit Per Occurrence	$ 1,000,000
Products/Completed Operations Aggregate	$ 2,000,000
Personal Injury and Advertising Injury	$ 1,000,000
General Aggregate	$ 2,000,000

(3) Professional Liability (Errors and Omissions) Insurance with at least minimum limits as follows. If "claims made" coverage is provided, "tail coverage" extending three (3) years beyond completion and acceptance of the project with proof of "tail coverage" to be submitted with the invoice for final payment. In lieu of "tail coverage", Proposer may submit annually to the County, for a three (3) year period, a current certificate of insurance providing "claims made" insurance with prior acts coverage in force with a retroactive date no later than commencement date of this contract.

Limits

Each Occurrence or Claim	$ 5,000,000
General Aggregate	$ 5,000,000

For acceptance of Professional Liability coverage included within another policy required herein, a statement notifying the certificate holder must be included on the certificate of insurance and the total amount of said coverage per occurrence must be greater than or equal to the amount of Professional Liability and other coverage combined.

(4) Cyber Risk Liability (Network Security/Privacy Liability) Insurance including cloud computing and mobile devices, for protection of private or confidential information whether electronic or non-electronic, network security and privacy; privacy against liability for system attacks, digital asset loss, denial or loss of service, introduction, implantation or spread of malicious software code, security breach, unauthorized access and use; including regulatory action expenses; and notification and credit monitoring expenses with at least minimum limits as follows:

Limits

Each Occurrence	$ 5,000,000
General Aggregate	$ 5,000,000

For acceptance of Cyber Risk Liability coverage included within another policy required herein, a statement notifying the certificate holder must be included on the certificate of insurance and the total amount of said coverage per occurrence must be greater than or equal to the amount of Cyber Risk Liability and other coverage combined.

EXHIBIT B

INSURANCE REQUIREMENTS

(5) Crime/Fidelity/Financial Institution Insurance coverage shall include Clients' Property endorsement similar or equivalent to ISO form CR 04 01, with at least minimum limits as follows:

Limits

Each Occurrence	$ 5,000,000
General Aggregate	$ 5,000,000

(6) Property Insurance Proposer will be responsible for all damage to its own property, equipment and/or materials.

EXHIBIT C

FEE SCHEDULE

Schedule of Financial Charges-Members

(Products and programs for Members enrolled in a CHLIC medical Plan)
Certain fees and charges identified in this Schedule of Financial Charges-Members 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	**$9.72/employee/month**
Medical	HSA Open Access Plus (OAP) with Care Management Preferred (All Plans)	**$9.72/employee/month**
	MEDICAL NETWORK ACCESS FEE, UTILIZATION MANAGEMENT FEE AND OPTIONAL PROGRAM FEE	
Product	**Description**	**Charge**
Medical	Integrated Medical/Rx Deductible PEPM Fee	**Included in Medical Administration Charge**
Medical	OAP Access Fee	**$26.27/employee/month**
Medical	HSA OAP Access Fee (All Plans)	**$26.27/employee/month**

EXHIBIT C

FEE SCHEDULE

MULTI-YEAR CHARGE/FEE GUARANTEES		
	The maximum increase for the Medical Administration Charge(s) and Network Access Fee(s) for the 2023 Plan Year will be 0.00% over the 2022 Plan Year charges/fees. The maximum increase for the Medical Administration Charge(s) and Network Access Fee(s) for the 2024 Plan Year will be 0.00% over the 2023 Plan Year charges/fees. The maximum increase for the Medical Administration Charge(s) and Network Access Fee(s) for the 2025 Plan Year will be 0.00% over the 2024 Plan Year charges/fees. The maximum increase for the Medical Administration Charge(s) and Network Access Fee(s) for the 2026 Plan Year will be 0.00% over the 2025 Plan Year charges/fees. The maximum increase for the Medical Administration Charge(s) and Network Access Fee(s) for the 2027 Plan Year will be 3.00% over the 2026 Plan Year charges/fees. The maximum increase for the Medical Administration Charge(s) and Network Access Fee(s) for the 2028 Plan Year will be 3.00% over the 2027 Plan Year charges/fees. The above fee guarantees are not applicable to Pharmacy Administration Fee. The above charges/fees are guaranteed for the time periods identified above, provided, however, that CHLIC may revise the above charges/fees pursuant to Section 8 of this Agreement.	

EXHIBIT C

FEE SCHEDULE

	CIGNA CHOICE FUND AND OTHER CONSUMER DIRECTED ACCOUNT ADMINISTRATION SERVICES AND CHARGES	
	Product	**Charge**
	Cigna Choice Fund Health Savings Account (HSA) Administration (Non-Cobra Only)	**For HSA OAP (HSA Actives) Products: $4.50/employee/month**
Health Advisor – A	The Health Advisor program focuses on engaging targeted Members related to a variety of wellness and prevention topics, and is designed to facilitate healthy behaviors and promote achievement of health-related goals. The program includes the following components: • Health and wellness coaching on high blood pressure, high cholesterol, healthy eating, physical activity and pre-diabetes using multiple coaching sessions, behavior modification techniques and other motivational interviewing and coaching styles to encourage behavior change that helps Participants reach established goals. • Education and referral coaching on program topics with referral to appropriate internal and external resources available. • Access to educational materials and web based Member tools and resources. • Identification of gaps in care and outreach to Member to provide coaching for those identified with gaps for high cholesterol, high blood pressure, and additional coaching on other gaps in care will also occur. • Support of Participants identified through predictive modeling with certain preference sensitive care conditions by supplying impartial evidence based medical information, to empower Participants to understand the potential benefits/ disadvantages of a specific course of action and make more informed care decisions. • Answering health and medical related questions. • Counseling Participants on prevention and the benefits of compliance with prescribed medications and treatments.	**For HSA OAP Only: Included in Medical Access Fee**

EXHIBIT C

FEE SCHEDULE

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

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

EXHIBIT C

FEE SCHEDULE

CHLIC MEDICAL COST CONTAINMENT FEES

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

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

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

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

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

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

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

CHLIC's per claim charge for administering the Non-Participating Provider Cost-Containment Programs in Section A of the table below plus any per claim vendor charges associated with the Non-Participating Provider Cost-Containment Programs in Section A of the table shall not exceed $30,000.00 per claim. Vendor charges for the Non-Participating Provider Cost-Containment Programs in Section A of the table generally range from 7-11% of gross savings. Specific rates charged by vendors for the programs in Section A of the table are available upon request, subject to execution of a mutually agreed upon non-disclosure agreement to protect the proprietary vendor information from unauthorized use/disclosure.

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

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

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

a. the amount of provider's billed charge not exceeding the greater of a CHLIC determined percentage of the Medicare allowable amount (the 80th percentile of the reasonable and customary charge if there is no Medicare allowable charge) or the amount required by state or

federal, law (in the case of emergency room services) for charges subject to CHLIC's benefit enhancement policy (patient may be balance billed by the provider if the provider's charge exceeds such amount), or

b. the provider's billed charge.

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

A. Non-Participating Provider Cost-Containment Programs		
1.	Network Savings Program	**29% of net savings**
2.	Supplemental Network	**29% of net savings**
3.	Medical Bill Review – (Pre-payment Cost Containment for Non-contracted claims):	
	Inpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
	Outpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
	Physician/Professional Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
B. Other Cost-Containment Programs		
1.	Medical Bill Review – (Pre or Post-payment Cost Containment for Non-contracted and Contracted claims):	
	• Bill Audit	**29% of the gross savings/gross recovery achieved plus hospital fees or expenses passed through**
	Diagnosis Related Grouping (DRG) Validation/Audits and Recovery. An overpayment audit and recovery program in which CHLIC or its vendors review paid claim data to identify overpayments based on inaccurate DRG coding.	**29% of gross savings/gross recovery plus any fees or expenses**

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

EXHIBIT C

FEE SCHEDULE

EMBARC BENEFIT PROTECTION[SM] 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 (Luxturna is the registered trademark of Spark Therapeutics, Inc. and Zolgensma is the registered trademark of AveXis, Inc.) As a result of this network contracting arrangement, eviCore is in most cases the exclusive, in-network Participating Provider of these drugs. eviCore arranges for the provision of these drugs through its network of specialty pharmacies (including its affiliate, Accredo), and certain facilities authorized to administer the gene therapies by the drug manufacturers. eviCore will reimburse these specialty pharmacies and facilities at negotiated reimbursement rates. This network solution is called Embarc Benefit Protection. For arranging for the provision of these drugs, eviCore will be reimbursed by CHLIC on a fixed Per Member Per Month (PMPM) basis. eviCore's PMPM fee (which is subject to change) will be charged to the Bank Account one month in arrears. (e.g., eviCore's charges for January will be made in February.) These Bank Account Payments will appear in Employer's monthly reporting. Embarc Benefit Protection does not provide financial protection from the cost of administering the two drugs. These costs are small in comparison to the drug costs. When covered under the Plan and determined by CHLIC to be medically necessary for the treatment of the specified conditions, Members will not incur any out-of-pocket costs for the two drugs and the Plan will not be required to reimburse any expenses for the two drugs with two exceptions: <u>Exceptions</u>: 1. For Members born before the date that Embarc Benefit Protection is effective for the Plan and receiving Zolgensma,® the Plan's in-network reimbursement and the Member's in-network cost-sharing apply to either (as applicable):	**$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 Benefit Protection book-of-business information for that calendar year.

	• 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 under its pharmacy benefits which are not administered by CHLIC, or iii. does not utilize a Cigna participating provider network. Upon Employer's request on or after the Effective Date, CHLIC shall provide to Employer an updated drug list, if applicable. CHLIC may revise charges/fees by giving Employer at least thirty (30) days' prior written notice.	

EXHIBIT C

FEE SCHEDULE

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)**
	• 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)**
	• 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**
	• 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.	**Fee reimbursement method and rates may vary by market and are available upon request**

	(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."	
	• 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**
	• 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.**
EXTERNAL REVIEW AND CONSULTATIVE REVIEW FEES		
	When a Member elects an External Review (as that term is defined in the Patient Protection and Affordable Care Act (PPACA)) of a benefit determination by an independent third party, the cost of a specific third party review is dependent on the nature and complexity of the issue on appeal. Third party review charges will be commensurate with the level of expertise necessary and the time required to complete the review.	**$500-$1,500 Review**
STRATEGIC ALLIANCES		
	CHLIC contracts directly or indirectly with other managed care entities and third party network vendors for access to their provider networks and discounts. These third parties charge either a network access fee, which is included in CHLIC's monthly charges, or a percentage of the savings realized on a claim by claim basis as a result of the application of their discounts. Charges based on percentage of savings may be paid from the Bank Account. Additional details regarding specific charges will be provided upon request.	**All Medical Products**

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

	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)**

EXHIBIT C

FEE SCHEDULE

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

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FEE SCHEDULE

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. Applicable if ESI is not the Pharmacy vendor**
ADDITIONAL SERVICES		
Service	**Description**	**Charge**
Fee Holiday	CHLIC shall make available to Employer a fund in the amount of $703,000.00 to be applied as determined by Employer against the Fees otherwise payable by Employer during the period of January 1, 2022 through June 30, 2022.	**Included at No Additional Charge**
Comprehensive Maternity Program	Cigna Healthy Pregnancies, Healthy Babies™ program is a comprehensive maternity management program. The goal of the program is to reduce the number of pre-term and underweight babies by promoting a healthy pregnancy. Expectant mothers can enroll using either the Cigna Pregnancy App (no additional cost for both Apple and Android platforms), or call to speak with a HPHB team member over the phone. The program delivers education and telephonic support to pregnant women through the post-partum period. Nurses answer medical related questions and make suggestions for behavior changes and medical interventions aimed at improving the health of the mother and baby. Program support also covers preconception and infertility. Financial incentives may be awarded to women at the completion of this self-referral program based on the trimester enrolled. Incentives Elected:	

	Option 3 (Low): $150 – 1st Trimester/$75 – 2nd Trimester	**For HSA OAP** **and OAP Products: Included in 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.	**For HSA OAP** **and OAP Products: Included in Medical Access Fee**
Clinical Program	A targeted condition medication therapy management program in which CHLIC provides support for Members using specialty medications for certain chronic conditions and that are obtained or administered at retail pharmacies or outpatient, office or home health care settings. As part of the program, Members are counseled on their condition, medication side effects, and importance of adherence. For the sake of clarity, if a specialty pharmacy affiliate of CHLIC provides therapy management for specialty medications the pharmacy dispenses to Members, then it does so in its capacity as a specialty pharmacy and not on behalf of CHLIC; CHLIC does not exert direction or control over the pharmacists at any specialty pharmacy affiliate.	**For HSA OAP** **and OAP Products: Included at No Additional Cost**

Premium Personal Health Team Program (Premium PHT)	The Premium Personal Health Team Program uses a designated Cigna health advocate team to provide identified Members the following personalized services: • Pre- and post- discharge calls when CHLIC is their medical plan administrator • Inpatient advocacy calls • Short-term and complex case management • Vendor referral and integration • Predictive modeling outreach • Coordination with Cigna onsite programs, as appropriate • 24-hour Health Information Line post follow up call outreach • Single point of contact for continuity in the advocate/Member relationship Members are identified for participation in the Premium Personal Health Team Program through a variety of sources including, but not limited to, clinical algorithms developed by CHLIC, self-enrollment, inpatient admissions, short-term and/or complex case management (medical).	**For HSA OAP** **and OAP Products: Included in Medical Access Fee**
Treatment Decision Support	A program that provides treatment decision support and coaching. Cigna health advocates provide unbiased information and education on treatment options for common health conditions, including: back pain, coronary artery disease, osteoarthritis of the hip and knee, benign uterine conditions, breast cancer and prostate cancer.	**For HSA OAP** **and OAP Products: Included in Medical Access Fee**

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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 HSA OAP** **and OAP Products: Included in Medical Access Fee**
Claim Litigation	Claim Litigation Services	**Included in Medical Administration Charge**

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Motivate*Me*® Incentives Program	The Motivate*Me* incentive program allows Employers to reward Members for taking steps to achieve health goals or make progress towards improving their health. Participating Members can earn rewards for active participation in CHLIC's health improvement programs and activities that focus on prevention, lifestyle and behavior modification and disease management. Participating Members track their incentive activity online and earn rewards as has been designated per the Employer's annual elections. Reward types include: HRA and Healthy Awards Account fund deposits, debit and/or gift cards, and Employer self-administered awards such as HSA fund deposits, healthcare premium adjustment and payroll deposit.	**For HSA OAP** **and OAP Products: Included in Medical Access Fee**
	Engage Package - includes administration of Employer selected CHLIC standard Incentives Program which provides Participating Members with Employer's pre-determined rewards. Activity to trigger incentives may include, but is not limited to, participation in the following available programs: Personal Health Analysis (CHLIC's health assessment), Social Health and Wellness, Wellness Screening (biometric), Online Health Coaching, Pre-Diabetes Digital Coaching, Self-Reported Activities, Steerage (Centers of Excellence facility steerage), Health Coaching by Phone, Case Management, Preventive Care (claim verified), Employer specific programs and Achieve Health Goals (biometric outcomes).	**For OAP** **and HSA OAP (HSA Actives) Products: Included in Medical Access Fee**

One Guide	The One Guide advocacy solution utilizes a multimodal approach to support Member and help them successfully navigate the health care system. Member are serviced by personal guides that include frontline service staff, as well as clinicians and non-clinician support staff from our medical, behavioral and pharmacy programs. In addition to connecting with personal guides via telephone, Member can also interact with personal guides via the click-to-chat feature on myCigna.com (web and app), enabling Member to engage with CHLIC and One Guide in the way in which they prefer. One Guide helps simplify and strengthen the connection between Member, their benefit plan, and their overall health and well-being. Through personalized and relevant messaging, One Guide proactively engages Member with clear ways to save money, stay healthy, and improve health outcomes that lead to a healthy lifestyle. One Guide offers: • education on health plan features, account balances and ways to maximize benefits and earn available incentives • guidance in finding the right doctor, lab, convenience care or pharmacy • immediate connection to health coaches and other resources The goal of One Guide is to help Members take care of what matters most- staying healthy, saving money, and improving health.	**For HSA OAP** **and OAP Products: Included in Medical Access Fee**
Virtual Health Center RN-Assisted Virtual Health Center	**Services.** Commencing at a date to be mutually agreed to in writing by the Parties ("Virtual Health Center Commencement Date") and continuing for the Term, Cigna will operate and staff a Virtual Health Center at the County and provide or arrange for the provision of the Virtual Health Center Services ("Services") described below, for the benefit of Participants (as defined herein). The Services shall be rendered by medical provider(s) who shall be provided for or arranged for by Cigna ("Virtual Provider") through telemedicine interactive audio-visual communication with Participants. A Cigna Registered Nurse Health Coach ("Cigna Personnel") shall provide assistance making the appointment with the Virtual Provider, entering patient data and summary into the medical record and otherwise assisting with the telemedicine visits by initiating the call, assisting with the equipment and connection, obtaining vitals and assistance with use of peripheral medical equipment. An example of services able to be provided at the Virtual Health Center are health and wellness services, immunization services, monitoring chronic conditions, laboratory services, biometric screening, lifestyle risk assessments, pharmacy, and primary care.	

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Onsite Resources		
	Onsite resources: the Parties shall meet and confer at the time of implementation to agree on the conditions and expectations of the onsite resources chosen regarding the exact scope of services, hours of operation, locations, language preferences, etc. so that these services are tailored to Pinellas County's needs. **1. Onsite Service Representative** DESCRIPTION OF SERVICES – The Onsite Service Representative will interact with internal/external customers and business partners, own customer issues, manage resolution in a timely manner and provide education and guidance about programs and resources available as a part of the benefit plan. They will assist in arranging case manager (or other appropriate resources) for customers with complicated medical conditions or technical/non-clinical needs. They will research, analyze and trach customer call/claim inquiries from employees. **2. Onsite Service Representative Back-up/Generalist** DESCRIPTION OF SERVICES - The Onsite Service Representative will support the Onsite Serve Representative in support of capacity and in back-up during time off. In addition, this role will serve as a generalist for project work supporting the County's human resources, benefits and wellness teams. **3. Registered Nurse (RN) Health Coach** DESCRIPTION OF SERVICES - The RN Health Coach has a clinical RN credential, combined with coaching experience. The RN Health Coach will assist participants with coaching, especially related to lifestyle improvement choices for clinical conditions such as diabetes, hypertension, hyperlipidemia, etc. This position will also assist in the Virtual Health Center when it has been established at a mutually agreed upon date. **4. Health Educator Coach** DESCRIPTION OF SERVICES - The Health Educator Coach has a health education background and is typically credentialed as a registered dietitian, physical activity specialist, etc. The Health Educator Coach will assist participants with coaching,	The cost of On-Site Resources, excluding Onsite EAP Provider is included in the Medical Administration Charge. Cost of the additional Onsite EAP Provider shall be paid through the Innovation Fund.

	especially related to lifestyle improvement choices related to nutrition, physical activity, stress management, etc. **5. Onsite EAP Provider (up to 19 hours per week)** DESCRIPTION OF SERVICES – The Onsite EAP Provider will be contracted to provide up to 19 hours per week to work onsite with your employees to address worksite needs within scope of EAP program. This is a convenient, direct way to access face to face EAP counseling.	
Virtual Health Center RN-Assisted Virtual Health Center	**Services.** Commencing at a date to be mutually agreed to in writing by the Parties ("Virtual Health Center Commencement Date") and continuing for the Term, Cigna will operate and staff a Virtual Health Center at the County and provide or arrange for the provision of the Virtual Health Center Services ("Services") described below, for the benefit of Participants (as defined herein). The Services shall be rendered by medical provider(s) who shall be provided for or arranged for by Cigna ("Virtual Provider") through telemedicine interactive audio-visual communication with Participants. A Cigna Registered Nurse Health Coach ("Cigna Personnel") shall provide assistance making the appointment with the Virtual Provider, entering patient data and summary into the medical record and otherwise assisting with the telemedicine visits by initiating the call, assisting with the equipment and connection, obtaining vitals and assistance with use of peripheral medical equipment. An example of services able to be provided at the Virtual Health Center are health and wellness services, immunization services, monitoring chronic conditions, laboratory services, biometric screening, lifestyle risk assessments, pharmacy, and primary care.	Virtual Health Center RN-Assisted Virtual Health Center
Employer 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 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.	**Included at No Additional Charge**

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	Fund amount: $50,000.00 Fund effective date: January 1, 2022 Fund will remain in effect until: December 31, 2022	
Actuarial Services Fund	CHLIC shall make available to Employer the designated amount to be used by Employer to: defray expenses associated with determining, assessing, and planning for the financial impact of risk. Fund amount: $5,000.00 Fund effective date: January 1, 2022 Fund will remain in effect until: December 31, 2022	**Included at No Additional Charge**
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: $30,000.00 Fund effective date: January 1, 2022 Fund will remain in effect until: December 31, 2022	**Included at No Additional Charge**

Innovation Fund	CHLIC shall make available to Employer the designated amount to be used by Employer to: defray its non-standard expenses associated with innovation of a new Plan or program subject to the following terms: Fund amount: $100,000.00 Fund effective date: January 1, 2022 - December 31, 2022 Effective January 1, 2023, the Innovation Fund will increase to $150,000.00 and will be available annually. Unused funds cannot be rolled over and CHLIC must pre-approve use of the Innovation Fund.	**Included at No Additional Charge**

Schedule of Financial Charges-Program Participants

(Health and Wellness programs for Program Participants)

Certain fees and charges identified in this Schedule of Financial Charges-Program Participants 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.

	HEALTH AND WELLNESS ADMINISTRATION CHARGES	
Product	**Description**	**Charge**
Health and Wellness	Health and Wellness Fee	**$1.85/employee/month**
	HEALTH AND WELLNESS SERVICES	
Health Assessment	The Cigna Health Assessment is an easy-to-use online questionnaire focused on a Program Participant's health and well-being. The assessment produces personal reporting for the Program Participant that provides a snapshot of overall health, and outlines areas in which the Program Participant is doing well and areas on which to focus.	**Included in Health and Wellness Fee**

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Health Information Line	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 Program Participants in finding the right care, make informed decisions about symptom-based health issues the Program Participant is experiencing when they call the Health Information Line and recommend appropriate settings for care. Health Information Line nurses can help inform and educate Program Participants about a wide variety of health and medical information, including access to a library of English and Spanish podcasts.	**Included in Health and Wellness Fee**
Lifestyle Management Program	Weight Management Program: The weight management Lifestyle Management Program offers assistance to Program Participants identified through claim data, the results of a health risk assessment questionnaire and/or self-enrollment. This program offers Program Participants a non-diet approach to weight loss that focuses on long-term lifestyle changes. The telephone coaching model offers one-to-one contact with a dedicated wellness coach who provides personalized, motivational support for the duration of the program. For Program Participants who prefer to work individually, web-based programs are available. The web-based program consists of online tools and articles with a supporting email campaign. Both telephone and online options focus on changing behaviors and providing Program Participants with practical strategies to help them.	**Included in Health and Wellness Fee**
Lifestyle Management Program	Tobacco Cessation Program: The tobacco cessation Lifestyle Management Program offers assistance to Program Participants identified through the results of a health risk assessment questionnaire and/or self-enrollment. This program provides interventions for all tobacco types and all “ready to change levels” (even for Program Participants not sure about quitting). The telephone coaching model offers one-to-one contact with a dedicated wellness coach who provides personalized, motivational support for the duration of the program. For Program Participants who prefer to work individually, web-based programs are available. The web-based program consists of online tools and articles with a supporting email campaign. Both telephone and online options focus on changing behaviors and providing Program Participants with practical strategies to help them. Both modalities include over the counter nicotine replacement therapy (patch or gum) at no cost to the Program Participant.	**Included in Health and Wellness Fee**

EXHIBIT C

FEE SCHEDULE

Lifestyle Management Program	Stress Management Program: The stress management Lifestyle Management Program offers assistance to Program Participants identified through the results of a health risk assessment questionnaire and/or self-enrollment. This program provides practical solutions for improving resilience to stress. The telephone coaching model offers one-to-one contact with a dedicated wellness coach who provides personalized, motivational support for the duration of the program. For Program Participants who prefer to work individually, web-based programs are available. The web-based program consists of online tools and articles with a supporting email campaign. Both telephone and online options focus on changing behaviors and providing Program Participants with practical strategies to help them.	**Included in Health and Wellness Fee**
Virtual Health Center RN-Assisted Virtual Health Center	**Services.** Commencing at a date to be mutually agreed to in writing by the Parties ("Virtual Health Center Commencement Date") and continuing for the Term, Cigna will operate and staff a Virtual Health Center at the County and provide or arrange for the provision of the Virtual Health Center Services ("Services") described below, for the benefit of Participants (as defined herein). The Services shall be rendered by medical provider(s) who shall be provided for or arranged for by Cigna ("Virtual Provider") through telemedicine interactive audio-visual communication with Participants. A Cigna Registered Nurse Health Coach ("Cigna Personnel") shall provide assistance making the appointment with the Virtual Provider, entering patient data and summary into the medical record and otherwise assisting with the telemedicine visits by initiating the call, assisting with the equipment and connection, obtaining vitals and assistance with use of peripheral medical equipment. An example of services able to be provided at the Virtual Health Center are health and wellness services, immunization services, monitoring chronic conditions, laboratory services, biometric screening, lifestyle risk assessments, pharmacy, and primary care.	

EXHIBIT C

FEE SCHEDULE

ADDITIONAL SERVICES		
Service	**Description**	**Charge**
Employee Assistance Program Services (EAP)	CHLIC provides the Employee Assistance Program Services ("EAP") for EAP Participants through its affiliate experienced in establishing and administering an EAP, Evernorth Behavioral Health, Inc. ("Evernorth"). For EAP Participants eligible to receive **six (6)** Clinical Services, the clinical component of the EAP Services provided to EAP Participants who reside in California is covered under the short-term counseling policy issued to Employer by CHLIC and not by the terms of this Agreement. All other EAP services for such EAP Participants are covered by the following terms. **EAP Participant:** Any person who is eligible to receive Evernorth EAP Services provided pursuant to this Agreement, including Employer's employees, their dependents and members of employees' households. **Clinical Services:** For mental health, alcoholism or drug abuse service ("Clinical Services"), assessment, referral and/or short-term problem resolution sessions will be provided, up to **six (6)** visits per assessed problem available for each eligible EAP Participant. **Work/Life Support Services**: For family care, legal/financial information, Healthy Rewards (telephonic), and Promotional Communications which includes but is not limited to, Frequently Asked Questions, Article Library, initial registration, online eligibility check, self-assessment tool and Provider Directory and Search vehicle Evernorth shall provide assessment and referral services as requested by EAP Participant or Employer. Legal assessment and referral services are not available to EAP Participants if the issue is related to a potential cause of action against Employer. Any additional services ("Menu Options") purchased by Employer are listed below. Services shall be provided by Evernorth through its employees and/or independent contractors. EAP Participant calls to the Evernorth toll-free number shall be handled by a personal advocate who shall refer the EAP Participant to an appropriate resource.	EAP fees are billed by Evernorth as follows: **1-6 Clinical Services and Work/Life Support Services:** $1.83*/employee/month *Due to enrollment in Cigna Total Behavioral Health, ("CTBH") the EAP fees for certain of Employer's employees otherwise eligible for the EAP, represents a blended rate which is lower than Evernorth's full-service EAP rate. If CTBH is discontinued under the medical plan and EAP is retained, the EAP fees will revert to Evernorth's full service EAP rate for Employer.

EXHIBIT C

FEE SCHEDULE

Service	Description	Charge
EAP *(continued)*	a) For Clinical Services, Evernorth shall offer an appointment promptly with a local counselor. In a Clinical Services' emergency, trained clinicians shall be available at Evernorth to telephonically address the situation and to make a referral to a local counselor or crisis intervention center for assessment, referral and/or short-term problem resolution. b) For Work/Life Support Services, Evernorth may refer Participant to contracted specialty firms or to local resources for assessment and referral. Participants shall be responsible for costs of services provided pursuant to a referral. Contracted specialty firms may offer Participant a discount rate. Work/Life Support legal services and/or financial services shall include, at no charge to Participants, an initial thirty (30) minute consultation. For Clinical Services, Evernorth shall maintain a nationwide network of local mental health and substance abuse counselors who shall assess the problem, provide short-term problem resolution and/or guide the EAP Participant to appropriate local treatment resources. Fees for Clinical Services other than assessment, referral and short-term problem resolution services within the maximum number of **six (6)** visits per assessed problem available per eligible EAP Participant shall be the EAP Participant's responsibility. Evernorth shall not represent to the EAP Participant that Evernorth's identification of or referral to treatment resources constitutes coverage under the provisions of EAP Participant's medical coverage plan. Communication materials related to EAP services are available electronically. Other EAP services Evernorth shall provide:	

EXHIBIT C

FEE SCHEDULE

Service	Description	Charge
EAP *(continued)*	a) Reports concerning utilization of EAP services by EAP Participants on a quarterly basis to Employer. Individually identifiable EAP Participant information shall be the property of Evernorth. Without the appropriate written consent of the EAP Participant, Evernorth shall provide no information to Employer or any third party that includes any EAP Participant specific identifiable information. Due to the sensitivity of EAP services, this provision is intended to be more stringent regarding the use or disclosure of PHI by CHLIC and/or its other affiliates than the Business Associate Agreement and as such, this paragraph shall prevail over any other provision in the Agreement or any of its Schedules or Exhibits and/or their Attachments. b) Management consultations to supervisors who request assistance for work related problems of employees. Evernorth shall provide assistance with mandatory referrals for employees who are required, under continuation of employment, drug free workplace or other workplace policies, to receive an assessment under the EAP. However, Evernorth shall not nor shall any of its network of providers provide advice and/or make a determination regarding an employee's (a) ability to safely perform the functions of his/her job, (b) ability to return to work after a medical disability, involuntary suspension from duties or administrative leave of absence, and/or (c) potential for workplace violence. No individually identifiable employee information concerning the employee's treatment shall be provided without the employee's written consent on a form approved by Evernorth. c) Employer Account Services: As part of Evernorth's Fees, Employer has purchased a number of hours for each twelve (12)	

*Available only if client has full or premium life event assistance as part of the EAP model purchased

	month period from the effective date of this Agreement for use in the delivery of the following Employer Account Services: (a.) Employee Orientation Sessions; (b.) Management/Supervisory Training Sessions; (c.) Educational/Wellness Seminars; (d.) Critical Incident Response Services; and/or (e.) Other Employer Account Services, e.g. Employer Account Services requested by Employer for which Evernorth notifies Employer that those services shall be counted against Employer Account Services' hours, including but not limited to, executive briefings, reduction in workforce counseling, and Employer's on-site EAP promotional activities conducted by Evernorth EAP managers or Evernorth contracted EAP affiliates.	
Service	**Description**	**Charge**
EAP *(continued)*	The number of hours to be provided by Evernorth for Employer Account Services in each twelve (12) month period shall be **10** hours per 1,000 employees (49 actual hours annually) based on the number of employees reported by Employer on the first Evernorth bill for that period. Pro-rata adjustments in this number of hours may be computed pursuant to Section 25B of the Agreement. Delivery of these Employer Account Services shall be as agreed upon by the parties. In the event Employer does not utilize or only partially utilizes these Employer Account Services during the twelve (12) month period to which they relate, Employer shall not be entitled to any refund or account credit, or to carry those hours forward. If Employer cancels its request for these services or reduces the number of hours initially requested after an independent provider has been secured by Evernorth. Additional Employer Account Services' hours beyond the annual available hours may be purchased by Employer at a rate of $250 per hour before the annual available hours have been exhausted. If Employer exceeds the annual available hours, then the rate for additional Employer Account Services' hours are $285 per hour for critical incident services and $255 per	

*Available only if client has full or premium life event assistance as part of the EAP model purchased

	hour for wellness seminars or management trainings. Delivery of these additional Employer Account Services shall be as agreed upon by the parties. Employer shall a) Provide information to Participants regarding access to the communication materials described above, and shall cooperate with Evernorth in other reasonable efforts to otherwise communicate with EAP Participants concerning the services available to them pursuant to this Agreement. b) Inform Evernorth of Employer's management policies and procedures that guide supervisors in handling employees with performance concerns in order for Evernorth to provide the training described above in Employer Account Services. Evernorth assumes no responsibility for the legal appropriateness of such policies and procedures. c) Annually, within ninety (90) days of the anniversary date of this Agreement, furnish to Evernorth the number of employees who are only EAP Participants by state of residence. Such number would not include employees who are EAP Participants who also have coverage for Mental/Health Substance Abuse services under the Plan.	
EAP *(continued)*	MENU OPTIONS Additional services are available for purchase by Employer at the rates set forth in Attachment 1. PERFORMANCE GUARANTEES Performance Guarantees are attached here to as Attachment 2.	

*Available only if client has full or premium life event assistance as part of the EAP model purchased

EXHIBIT D

PAYMENT/INVOICES

PAYMENT/INVOICES:
SUPPLIER shall submit invoices for payment due as provided herein with such documentation as required by Pinellas County and all payments shall be made in accordance with the requirements of Section 218.70 *et. seq,* Florida Statutes, "The Local Government Prompt Payment Act." Invoices shall be submitted to the address below unless instructed otherwise on the purchase order, or if no purchase order, by the ordering department:

Finance Division Accounts Payable
Pinellas County Board of County Commissioners
P. O. Box 2438
Clearwater, FL 33757

Each invoice shall include, at a minimum, the Supplier's name, contact information and the standard purchase order number. In order to expedite payment, it is recommended the Supplier also include the information shown in below. The County may dispute any payments invoiced by SUPPLIER in accordance with the County's Dispute Resolution Process for Invoiced Payments, established in accordance with Section 218.76, Florida Statutes, and any such disputes shall be resolved in accordance with the County's Dispute Resolution Process.

INVOICE INFORMATION:

Supplier Information Company name, mailing address, phone number, contact name and email address as provided on the PO

Remit To	Billing address to which you are requesting payment be sent
Invoice Date	Creation date of the invoice
Invoice Number	Company tracking number
Shipping Address	Address where goods and/or services were delivered
Ordering Department	Name of ordering department, including name and phone number of contact person
PO Number	Standard purchase order number
Ship Date	Date the goods/services were sent/provided
Quantity	Quantity of goods or services billed
Description	Description of services or goods delivered
Unit Price	Unit price for the quantity of goods/services delivered
Line Total	Amount due by line item
Invoice Total	Sum of all of the line totals for the invoice

Pinellas County offers a credit card payment process (ePayables) through Bank of America. Pinellas County does not charge vendors to participate in the program; however, there may be a charge by the company that processes your credit card transactions. For more information please visit Pinellas County purchasing website at www.pinellascounty.org/purchase.

*Available only if client has full or premium life event assistance as part of the EAP model purchased

EXHIBIT D

PAYMENT/INVOICES

Payment of invoices for work performed for Pinellas County Board of County Commissioners (County) is made, by standard, in arrears in accordance with Section 218.70, et. seq., Florida Statutes, the Local Government Prompt Payment Act.

If a dispute should arise as a result of non-payment of a payment request or invoice the following Dispute Resolution process shall apply:

A. Pinellas County shall notify a vendor in writing within ten (10) days after receipt of an improper invoice, that the invoice is improper. The notice should indicate what steps the vendor should undertake to correct the invoice and resubmit a proper invoice to the County. The steps taken by the vendor shall be that of initially contacting the requesting department to validate their invoice and receive a sign off from that entity that would indicate that the invoice in question is in keeping with the terms and conditions of the agreement. Once sign off is obtained, the vendor should then resubmit the invoice as a "Corrected Invoice" to the requesting department which will initiate the payment timeline.

1.) Requesting department for this purpose is defined as the County department for whom the work is performed.

2.) Proper invoice for this purpose is defined as an invoice submitted for work performed that meets prior agreed upon terms or conditions to the satisfaction of Pinellas County.

B. Should a dispute result between the vendor and the County about payment of a payment request or an invoice then the vendor should submit their dissatisfaction in writing to the Requesting Department. Each Requesting Department shall assign a representative who shall act as a "Dispute Manager" to resolve the issue at departmental level.

C. The Dispute Manager shall first initiate procedures to investigate the dispute and document the steps taken to resolve the issue in accordance with section 218.76 Florida Statutes. Such procedures shall be commenced no later than forty-five (45) days after the date on which the payment request or invoice was received by Pinellas County, and shall not extend beyond sixty (60) days after the date on which the payment request or invoice was received by Pinellas County.

D. The Dispute Manager should investigate and ascertain that the work, for which the payment request or invoice has been submitted, was performed to Pinellas County's satisfaction and duly accepted by the Proper Authority. Proper Authority for this purpose is defined as the Pinellas County representative who is designated as the approving authority for the work performed in the contractual document. The Dispute Manager shall perform the required investigation and arrive at a solution before or at the sixty (60) days timeframe for resolution of the dispute, per section 218.76, Florida Statutes. The County Administrator or his or her designee shall be the final arbiter in resolving the issue before it becomes a legal matter. The County Administrator or his or her designee will issue their decision in writing.

E. Pinellas County Dispute Resolution Procedures shall not be subject to Chapter 120 of the Florida Statutes. The procedures shall also, per section 218.76, Florida Statutes, not be intended as an administrative proceeding which would prohibit a court from ruling again on any action resulting from the dispute.

F. Should the dispute be resolved in the County's favor interest charges begin to accrue fifteen (15) days after the final decision made by the County. Should the dispute be resolved in the vendor's favor the County shall pay interest as of the original date the payment was due.

*Available only if client has full or premium life event assistance as part of the EAP model purchased

EXHIBIT D

PAYMENT/INVOICES

G. For any legal action to recover any fees due because of the application of sections 218.70 et. seq., Florida Statutes, an award shall be made to cover court costs and reasonable attorney fees, including those fees incurred as a result of an appeal, to the prevailing party If it is found that the non-prevailing party held back any payment that was the reason for the dispute without having any reasonable lawful basis or fact to dispute the prevailing party's claim to those amounts.

*Available only if client has full or premium life event assistance as part of the EAP model purchased

ATTACHMENT 1 - EAP Optional Service Offerings

Back-Up Care Advantage Program*

Priced individually per client based on client-specific data and demographics

- Includes administration of an employer subsidy for back- up care and assistance to employees in securing back-up care services throughout the year
- Provided through Bright Horizons and offers three types of quality care: center-based child care, in-home child care, and in-home adult/elderly care.
- Crisis Care Assistance during natural disasters, national health alters and other emergencies. Support for business continuity planning.

Care Coach*

Note: this is included in the Premium Work/Life assistance bundle.

$0.19 PEPM as a buy up to EAP clients with Full Work/Life assistance.

- Telephonic services, which include a family meeting with a qualified Geriatric specialist who:
    - conducts a detailed interview with family members
    - completes an assessment and review of relevant records and evaluations to identify challenges
    - helps establish a geriatric care plan and
    - identifies resources that family members can agree upon
- Can also be used for special needs adult, in addition to seniors in need of a care plan
- A care plan document is reviewed in a follow up telephone meeting and provided so that the family can follow the recommendations agreed upon

Care Kits*

Note: The Premium Work/Life assistance bundle includes *consultant-driven* Care Kits at no additional cost. This means relevant mini and standard Care Kits can be offered by the work/life specialist when relevant to a customer's work/life request for resource referrals. This differs from the buy up.

Care Kits provide resources tied to specific work/life issues that occur throughout the lifecycle, e.g., caregiver support, nursing mother support, child safety and more. Client organizations have options regarding:

- Type of kit (mini, standard, premium or super premium)
- Maximum annual quantity or no limit
- Selected Care Kit titles offered to the employee population Care Kits* (continued)

A listing of available Care Kits will be provided upon request.
The unit cost decreases by tier throughout each year, as shown below. For example, the first nine standard care kits purchased will cost $110 per kit. The unit cost then decreases to $100 per kit. When a combined total of 50 kits have been fulfilled, the unit cost decreases to $95 per kit.

*Available only if client has full or premium life event assistance as part of the EAP model purchased

	Price tiers per kit (quantity resets annually)		
Type of Kit	**< 10 kits**	**10- 50 kits**	**> 50 kits**
Mini Care Kits	**$50 per kit**		
Standard Care Kits	**$110**	**$100**	**$95**
Premium Care Kits (includes Swing Pump)	**$180**	**$165**	**$155**
Super Premium Care Kits (includes Electronic Pump)	**$430**	**$395**	**$370**

Department of Transportation/Substance Abuse Professional (DOT/SAP) Services

$950 per case

- Assesses employees to determine necessary assistance
- Refers employees to appropriate network providers and assists with placement
- Communicates the specific recommendations directly to the Employer representative
- Monitors employee's compliance with the recommendations
- Evaluates employees to determine the success of the treatment
- Provides a written compliance letter

Enhanced Financial and Legal Services†

Note: this is included in the Premium Work/Life assistance bundle.

$0.07 PEPM as a buy up to EAP clients with no work/life, self-service or full work/life assistance

- Free 60-minute telephonic consultation with a financial professional
- 25% discount for tax preparation
- Customer option to continue with self-paid financial coaching program on a month-to-month basis
- Free 60-minute consultation with a network attorney; can be by phone or in-person
- 25% discount for usual legal fees if the network attorney is retained

† Employment-related matters are not covered.

*Available only if client has full or premium life event assistance as part of the EAP model purchased

Extended Care Follow-up

$1,150 per case

- 12-month guided support for employees who have been referred through the management referral process.
- A comprehensive service that includes not only assessment and referral, but also evaluation and monitoring.

Fitness for Duty Evaluation Services

Case rate depends on scope of services and geographic location (average cost is $3,300-$4,600 per case)

- A behavioral fitness for duty referral usually stems from an employer's concern regarding symptoms or behaviors that have the potential to negatively impact the workplace or employees' safety.
- The referral process is facilitated by one of our Employee Assistance Consultants (EACs), who provide consultation and managerial support in determining the need for such an evaluation.
- Once the need is established, the EAC helps define the questions and concerns to be addressed by the assessor, and then coordinates a referral to PsyBar, a contracted service provider who performs the evaluation.
- The EAC communicates the results of the evaluation to the employer (first verbally, then in a written report), and then assists both employer and employee with ongoing treatment and return-to-work planning, as needed.
- Payment of all PsyBar fitness-for-duty service fees associated with Fitness for Duty and Behavioral Risk Assessments is the responsibility of the employer/entity requesting the service. Please be aware that there will also be an additional fee charged by the examiner if the appointment is canceled once scheduled or if the employee does not present in the examiner's office at the scheduled time.

Geriatric Case Management*

$400 Implementation cost plus the appropriate PEPM for the selected program offering:

a) 4 Hour Block - $0.19 PEPM; or

b) 6 Hour Block - $0.25 PEPM

- Comprehensive assessment with a qualified Geriatric Case manager which includes meeting with the family, an onsite assessment of the loved one's living environment and care needs, and creation of a detailed care plan
- Can include an assessment of possible housing options, if necessary

International Employee Assistance Programs

International Employee Assistance Program services provide assistance to expatriates and in-country employees, as well as global resources for training, critical stress management response and management consultation and referrals. Pricing is dependent on enrollment and program model by country. Proposal and pricing are available upon request.

Product Model	Core EAP Services
International EAP Level 1 Regional Answer	Telephonic
International EAP Level 2 Regional Answer	Telephonic and Face-to-Face
International EAP Level 3 Regional Answer	Telephonic, Face-to-Face and Work/Life

*Available only if client has full or premium life event assistance as part of the EAP model purchased

International EAP Level 3 Local Answer	Telephonic, Face-to-Face and Work/Life

Lactation Program*

Cost depends on selected option as noted below; pump/kit options range from $180-$500

- Offers educational resources and telephonic support for breastfeeding mothers before and after the birth of a child, as well as during return-to-work.
- Additionally, on-site programs can offer assessments and consultation to help workplaces become more nursing-friendly.

Lactation consultation services, which are offered at three levels of support detailed below, include prenatal education; postnatal counseling by certified lactation consultants; and tip sheets.

Lactation Consultation	Nursing Mother Assist Fundamental	Nursing Mother Assist Custom	Nursing Mother Assist Complete
Includes:	2 scheduled calls: • 1 pre-natal educational phone call • 1 return-to-work consultation	4 scheduled calls, based on nursing mother's preference and needs. Typically this includes: • 1 pre-natal educational phone call • 1 consultation within the first week after delivery • 1 consultation mid-maternity leave • 1 return-to-work consultation	10 scheduled calls: • 1 pre-natal educational phone call • 4 weekly calls during maternity leave • 1 return-to-work consultation • 4 monthly calls after returning to work
Pricing:	$225 per case	$410 per case	$525 per case

*Available only if client has full or premium life event assistance as part of the EAP model purchased

Legal & Financial Seminars

$215-$640 per seminar*

- Standard titles as listed in the EAP seminar catalog
- Tailored, based on titles listed in the EAP seminar catalog with minor adaptations
- Customized

***Employer Service Hours (ESH) can be used by EAP clients based on a ratio of 2 ESH for each hour used for legal and financial seminars, which are identified in the EAP seminar catalog

Nanny Find*

$3,000 per case

- Provides expert assistance and guidance during the nanny recruitment and hiring process, including recruitment of nanny candidates matching the customer profile, scheduling and support for the interview process, background check and contracting support
- Parents also have continuous access to care experts long after the nanny search is completed

Professional Coaching

$517 per hour for a minimum of three hours per case

- Provides Professional and Executive Coaching Services to individuals and employers upon request.
- Cigna Professional and Executive Coaching is for all types of employees on all different levels in the organization.
- Coaches can work one-on-one to address individual needs and opportunities, or in a group setting to address company-wide issues, such as communication with leadership, conflict resolution and team- building.

Subsidy Assist Program*

One-time $1500 implementation fee; case rates depend on the service model purchased: Subsidy Gatekeeper: $100 per case, or Subsidy Management: $200 per case; Consulting:
$2,000 per Diem

- Helps clients in the development and management of employer subsidy programs to support employees with targeted work/life expenses, i.e., Adoption Subsidy Assist Program; Surrogacy Subsidy Assist Program, etc.
- Two service model options are available, depending on the needs of the employer:
  - Subsidy Gatekeeper: handles intake and initial review/coordination to ensure claims are complete before handoff to employer or designated third party who makes determinations and processes any payments
  - Subsidy Management: handles intake, initial review/coordination, validates all entities tied to a claim, e.g., adoption agency; makes determinations in accordance with the client's policy; communicates with employee regarding status of claims; forwards decisions on each claim to the employer or designated third party for payment; supports appeals process; and tracks subsidy balance for each employee family.
  - Consulting is available and is required if employer does not have a subsidy assistance program policy in place; can also be used to review and revise an existing policy.

*Available only if client requests custom life event assistance as part of the EAP model purchased

ATTACHMENT 2 – EAP PERFORMANCE GUARANTEES

Employee Assistance Program – Pinellas County Board of Commissioners Performance Guarantees

Performance standards will be measured annually per the parameters in the following table. We routinely monitor these standards to ensure we are meeting our customers' needs. Because of our outstanding capabilities and the confidence we have in our service delivery, we are pleased to offer 15% of the administrative fees at risk, plus an additional 5% for a successful implementation. The proposed 20% will be allocated according to the table below.

Performance Category	Performance Criteria	Performance Standard	Measurement Criteria Criteria will be paid based on the respective incremental levels.	Weighted Fees at Risk	Fees at Risk	Customer Specific	Measurement/ Reporting Period
Telephone Responsiveness	Average Speed of Answer*:	Average speed of answer no greater than 30 seconds.	30.1 - 30.9 seconds 31.0 - 31.9 seconds 32.0 - 32.9 seconds 33.0 - 34.9 seconds >35.0 seconds	1/5 2/5 3/5 4/5 5/5	2%	Yes	Contract Year
Telephone Responsiveness	Call abandonment*:	Call abandonment rate less than 3%.	5.0 – 5.9% 6.0 – 6.9% 7.0 – 7.9% 8.0 – 8.9% >9.0%	1/5 2/5 3/5 4/5 5/5	1%	Yes	Contract Year
EAP Satisfaction	Overall Participant Satisfaction:	90% overall satisfaction based on annual survey.	89.9 – 88.0% 87.9 – 86.0% 85.9 – 84.0% 83.9 – 82.0% <82.0%	1/5 2/5 3/5 4/5 5/5	2%	No	Contract Year
Management Services	Delivery of standard management reports:	Standard management reports will be made available via the *Internet* within 30 working days after the end of the reporting period.	16 days 17 days 18 days 19 days 20+ days	1/5 2/5 3/5 4/5 5/5	2%	Yes	Quarterly

Performance Category	Performance Criteria	Performance Standard	Measurement Criteria Criteria will be paid based on the respective incremental levels.	Weighted Fees at Risk	Fees at Risk	Customer Specific	Measurement/ Reporting Period
Implementation	Implementation Plan:	Mutually agreed upon deadlines will be met as outlined in the Implementation Plan	Flat 5% if implementation deadlines are not met. (This 5% is over and above the 15% Evernorth may put at risk for other PGs. This is only valid the first year of a contract).	All	5%	Yes	One Time
EAP Satisfaction	Management Consultation/ Referral Satisfaction:	90% satisfaction based on surveys returned from supervisors utilizing services.	89.9 – 88.0% 87.9 – 86.0% 85.9 – 84.0% 83.9 – 82.0% <82.0%	1/5 2/5 3/5 4/5 5/5	2%	No	Calendar Year
EAP Satisfaction	EAP Seminar/ Training Satisfaction:	90% satisfaction based on surveys received from primary contact at employer organization.	89.9 – 88.0% 87.9 – 86.0% 85.9 – 84.0% 83.9 – 82.0% <82.0%	1/5 2/5 3/5 4/5 5/5	2%	No	Calendar Year
EAP Satisfaction	Critical Incidence Response Satisfaction:	90% satisfaction based on surveys received from primary contact at employer organization.	89.9 – 88.0% 87.9 – 86.0% 85.9 – 84.0% 83.9 – 82.0% <82.0%	1/5 2/5 3/5 4/5 5/5	2%	No	Calendar Year
Network	Recruitment	90% of employees shall have access to 2 EAP practitioners within 10 miles (Urban/Suburban); 90% of employees shall have access to 1 EAP practitioner within 25 miles (Rural)	89.9 – 88.0% 87.9 – 86.0% 85.9 – 84.0% 83.9 – 82.0% <82.0%	1/5 2/5 3/5 4/5 5/5	2%	Yes for accounts with 25,000 or more covered lives, otherwise book of business	Calendar Year

* Only applicable to accounts with dedicated phone lines.

† Evernorth Behavioral Health, Inc. is pleased to work with Pinellas County Board of Commissioners to identify mutually agreeable parameters and place fees at risk for these guarantees once Pinellas County Board of Commissioners' specific needs have been identified.

Attachment 3 – Performance Guarantees

Medical Performance Guarantee Agreement

By and Between

Pinellas County Board of Commissioners

"County"

And

Cigna Health and Life Insurance Company

And Applicable Affiliates

Collectively "CHLIC"

Effective Date: January 1, 2022

Table of Contents

Performance Guarantees and Penalties

MEDICAL IMPLEMENTATION

Identification Card Delivery Implementation ID Card Timeliness. 98% of the ID cards will be mailed by the agreed upon Commitment Date in the Implementation Calendar. Results measured at Account Level.	Amount At Risk 1.85% of Admin. Fees
Claim Readiness Implementation Claim Readiness. Benefit Profile and eligibility information loaded on claims processing system as of the Commitment Date set forth in the approved Implementation Calendar. Results measured at Account Level.	Amount At Risk 1.85% of Admin. Fees
Call Readiness Implementation Call Readiness. Service Center(s) ready to respond to customer inquiries as of the Commitment Date set forth in the approved Implementation Calendar. Results measured at Account Level.	Amount At Risk 1.85% of Admin. Fees
Implementation Satisfaction Implementation Satisfaction. Score of no less than three (3) on the question: Overall, how satisfied were you with your most recent installation experience with Cigna? in the Cigna HealthCare Implementation Survey. Results measured at Account Level.	Amount At Risk 1.85% of Admin. Fees

MEDICAL SERVICE

Claim Time-to-Process Medical Time to Process. Measured for the Term of the Agreement, results will meet or exceed: 94% of Claims Processed within 14 calendar days. Results measured at Account Level.	Amount At Risk 1.85% of Admin. Fees
Claim Time-to-Process Medical Time to Process. Measured for the Term of the Agreement, results will meet or exceed: 99% of Claims Processed within 30 calendar days. Results measured at Account Level.	Amount At Risk 1.85% of Admin. Fees

MEDICAL SERVICE

Financial Accuracy Medical Financial Accuracy. Measured for the Term of the Agreement, results will meet or exceed: 99.3% of total audited Claim dollars are correctly paid. Results measured at Account Level.	Amount At Risk 1.85% of Admin. Fees
Processing Accuracy Medical Processing Accuracy (Overall Accuracy). Measured for the Term of the Agreement, results will meet or exceed: 98% of total audited Claims are correctly Processed. Results measured at Account Level.	Amount At Risk 1.85% of Admin. Fees
Processing Accuracy Medical Processing Accuracy (Overall Accuracy). Measured for the Term of the Agreement, results will meet or exceed: 96% of total audited Claims are correctly Processed. Results measured at Account Level.	Amount At Risk 1.85% of Admin. Fees
Payment Accuracy Medical Payment Accuracy. Measured for the Term of the Agreement, results will meet or exceed: 98% of total audited Claims are correctly paid. Results measured at Account Level.	Amount At Risk 1.85% of Admin. Fees
Gross Adjustment Rate Medical Gross Adjustment Rate. Measured for the Term of the Agreement, results will not exceed: 6% of total Claims Processed adjusted. Results measured at Account Level.	Amount At Risk 1.85% of Admin. Fees
Average Speed of Answer Medical ASA. Measured for the Term of the Agreement, results will not exceed: 30 seconds to answer a Call. Results measured at Special Account Queue Level.	Amount At Risk 1.85% of Admin. Fees
Call Abandonment Rate Medical Call Abandonment Rate. Measured for the Term of the Agreement, results will not exceed: 2% of Calls received terminated. Results measured at Special Account Queue Level.	Amount At Risk 1.85% of Admin. Fees
First Call Resolution Medical First Call Resolution. Measured for the Term of the Agreement, results will meet or exceed: 90% of Calls resolved on first Inquiry, 45 day look back/forward. Results measured at Account Level.	Amount At Risk 1.85% of Admin. Fees

MEDICAL SERVICE

Call Activity Closure Medical Call Activity Closure. Measured for the Term of the Agreement, results will meet or exceed: 95% of Calls closed in 5 Business Days. Results measured at Account Level.	Amount At Risk 1.85% of Admin. Fees
CSA Quality Medical CSA Quality. Measured for the Term of the Agreement, results will meet or exceed: 95% quality standard. Results measured at Account Level.	Amount At Risk 1.85% of Admin. Fees
Automated Maintenance Eligibility Processing Auto Eligibility Processing. Measured for the Term of the Agreement, results will meet or exceed: 100% files processed in 2 Business Days after the receipt of clean eligibility. Results measured at Account Level.	Amount At Risk 1.85% of Admin. Fees
ID Card Maintenance Combined (Medical/Dental) ID Cards Maintenance. Measured for the Term of the Agreement, results will meet: 100% mailed within 5 Business Days after the release of, not receipt of, clean and accurate eligibility to the ID card vendor. Results measured at Account Level.	Amount At Risk 1.85% of Admin. Fees
Account Management Account Management. Monthly Reports will be available within 10 days following the month's end. Results measured at Account Level.	Amount At Risk 1.85% of Admin. Fees
Account Management Account Management. Composite Score (all categories) of 3.0 or better on the Account Management Report Card based on four (4) quarterly scorecards. Results measured at Account Level.	Amount At Risk 1.85% of Admin. Fees
Provider Medical Provider Voluntary Turnover. Provider Voluntary Turnover/Network Disruption in each network location offered by Pinellas County will be less than 5% per year. Results measured at Book of Business Level.	Amount At Risk 1.85% of Admin. Fees

MEDICAL SERVICE

Overpayment Recovery Overpayment Recovery - 80% in 18 Months. CHLIC shall notify Employer of the full amount of all overpayments on a quarterly basis and identify any overpayments not recovered within 18 months from the date the overpayment was identified. For Administrator Overpayments captured within CHLIC's baseline overpayment identification programs, CHLIC will recover a minimum of 80% of the identified dollars within 18 months from the time that the overpayment is identified. If we do not meet this metric, the penalty will be the lesser of the dollar risk stated in the agreement, or the difference between the percentage amount recovered and the 80% goal. Results measured at Account Level.	Amount At Risk 1.85% of Admin. Fees
Data Feeds Health benefit plan data feeds to data warehouse partner Medical data delivered completely and accurately by the 20th of the month after the close of the month. Results measured at Account Level.	Amount At Risk 1.85% of Admin. Fees
Data Delivery Clinical and/or wellness program participant or population-based outcomes for clinical and financial metrics Health management and wellness program data delivered completely and accurately by the 20th of the month after the close of the quarter. Financial information may only be available annually. Results measured at Account Level.	Amount At Risk 6.00% of Admin. Fees
Data Feeds Wellbeing Guarantees: Feed to data warehouse: Cigna can commit to sending feeds by the 30th of each month. Results measured at Account Level.	Amount At Risk 6.00% of Admin. Fees
Member Website Member website will be available at least 99% of core hours. myCigna Standard Hours of Availability (all times shown are Eastern): myCigna is continually available from 12:01 a.m. on Monday through 11:59 p.m. on Saturday; and between 10:00 a.m. and 11:59 p.m. on Sunday, except on major release weekends, when the hours will be posted online. Please note that updated claim data may NOT be available between 10:00 p.m. and 11:59 p.m. on Saturdays, or on Mondays between 12:01 a.m. and 1:00 a.m. due to scheduled site maintenance. Results measured at Account Level.	Amount At Risk 1.85% of Admin. Fees

CLINICAL

Incentives	Amount At Risk
Cigna will deliver the incentive program, free of any major defects, by 1/1/2022. Major defects include an issue which prevents MotivateMe from accurately administering incentives. The issue must impact 3% or more of the population and have financial impact to the client of greater than $50,000. Incentives that MotivateMe cannot standardly administer are excluded from this guarantee. If Cigna does not achieve the performance guarantee by the date above, Cigna will refund 5% of MotivateMe fees.	5% of MotivateMe Fees

Integrated Advocacy	Amount At Risk
Integrated Advocacy - One Guide with HMCM Premium Preferred. Ratio of Savings to Integrated Advocacy Fees Spent: 4:1. One year Guarantee Period. Results measured at Client Specific Level. Integrated Advocacy Fees at Risk. Payout tiered. See 3.3 for details. Actual ROI/Payout >/=4.0: 0% 3.50 - <4.00% 25% 3.00 - <3.50% 50% 2.50 - <3.00% 75% <2.50 - 100%	$75,000.00

YOUR HEALTH FIRST

Your Health First Account Metrics	Amount At Risk
YHF200 - Over 500 Buyer Group - 3000-4999 – Engagement. See 3.4 for details. Results measured at Client Specific Level.	30.00% of YHF Fees

Your Health First Account Metrics	Amount At Risk
At least 90% of survey responses received from individuals participating in Cigna's Your Health First program will indicate overall satisfaction with their Your Health First experience. One-year guarantee period. Results measured at Book of Business Level.	$14,460.00

TREND

One Way Medical Trend Guarantee. See 3.5 for details.

Performance Guarantee Agreement

This Performance Guarantee Agreement ("**Agreement**") is between Cigna Health and Life Insurance Company and applicable affiliates (collectively "**CHLIC**" or "**Cigna**") and Pinellas County Board of Commissioners ("**County**") each a "Party" and collectively, the "Parties," and is effective on January 1, 2022 ("**Effective Date**").

WHEREAS, in connection with certain services and programs that CHLIC is providing to Employer in connection with one or more employee welfare benefit plans sponsored by Employer (the "**Plan(s)**") under the applicable agreements between the Parties (individually or collectively, the "**Service Agreements and/or Policies**", effective January 1, 2022), CHLIC and Employer desire to implement the performance guarantees identified in Attachment 3 attached hereto, according to the terms set forth in this Agreement.

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein, CHLIC and Employer hereby agree as follows:

Section 1. – Term and Termination

1. This Agreement is effective on the Effective Date and shall remain in effect for one (1) year or such other period specified in the applicable Attachment 3 (the "**Term**") unless terminated sooner upon the earliest of the following dates:

1.1. The date when CHLIC ceases to administer the Plan(s) (other than run-out claim administration) or when the applicable Service Agreements and/or Policies are terminated or suspended;

1.2. The date when any state or other applicable jurisdiction prohibits the activities of the Parties under this Agreement;

1.3. The Effective Date, in the event that any condition precedent listed in Section 3 or in the applicable Attachment 3 subsection is not satisfied.

2. This Agreement is not renewable unless otherwise specified in the applicable Attachment 3 subsection.

Section 2. – Definitions

1. The following terms used in this Agreement are defined as follows. Additional definitions applicable to a specific Performance Guarantee may be included in Attachment 3. Terms not defined in this section, the applicable Attachment 3, or otherwise in this Agreement shall be deemed to reflect the commonly understood industry meaning.

1.1. Account Level - means that performance shall be measured based upon performance with respect to the Employer's Plan(s) to which the Performance Guarantee applies.

1.2. Applicable Law - means the state, federal and/or regulation that apply to a Party or the Plan.

1.3. Benefit Profile - means the benefits offered under a Plan, including plan design and structure.

1.4. Book of Business Level – means that performance shall be measured based upon all plans insured and or administered by CHLIC and its affiliates as determined by CHLIC.

1.5. Business Days – means the days of the week that CHLIC is open to the public for conducting business.

1.6. Employee – means a person who is employed by Employer and covered under the Plan(s).

1.7. Guarantee Period – means the period during which CHLIC's performance that is the subject of the Performance Guarantee will be measured, which shall be one (1) year from the Effective Date, unless otherwise specified in the applicable Attachment 3 subsection.

1.8. Party/Parties - means Employer and CHLIC, each a "Party" and collectively, the "Parties".

1.9. Payment Amount – means the amount payable, as determined by CHLIC under the criteria set forth in this Agreement, pursuant to the terms of a Performance Guarantee.

1.10. Performance Guarantees – means the guarantees identified in Attachment 3 pursuant to which CHLIC commits to achieving specified levels of performance in connection with the applicable Service Agreements and/or Policies.

1.11. Plan Participants – means eligible persons enrolled in the applicable Plan(s) to which the specific Performance Guarantee applies.

1.12. Projected Population – means the number of Employees that Employer estimated would be enrolled in the applicable Plan(s) to which the specific Performance Guarantee applies on the Effective Date which is 3,283 medical enrolled Employees.

Section 3. – Conditions Precedent

1. Employer acknowledges and agrees that the following conditions precedent must be met in order for any Performance Guarantee set forth in this Agreement to be in effect, otherwise such Performance Guarantee is null and void:

1.1. This Agreement is signed by both Parties within three (3) months of the Effective Date;

1.2. Employer does not make a material change in Benefit Profile during the Term that, as reasonably determined by CHLIC, affects the performance being measured in the applicable Performance Guarantee;

1.3. CHLIC continuously administers the services to which the applicable Performance Guarantee applies for the entire Term;

1.4. Employer must be an active client of CHLIC for the type of coverage(s) to which this Agreement relates (e.g. Medical, Dental, Pharmacy, Vision, etc.) at the time any Payment Amount is otherwise payable by CHLIC under this Agreement;

1.5. This Agreement remains continuously in effect for the entire Term;

1.6. The Plan(s) applicable to a specific Performance Guarantee remains in effect throughout the Term;

1.7. The applicable Service Agreements and/or Policies to which the Performance Guarantee relates remains in effect throughout the Term of this Agreement, or the Employer treats the applicable Service Agreements and/or Policies as being in effect by materially performing its duties and obligations under the applicable Service Agreements and/or Policies throughout the Term of this Agreement;

1.8. The conditions precedent set forth in Attachment 3 of a specific Performance Guarantee are met.

Section 4. – Evaluation of Performance and Payment Amounts

1. Performance Guarantees and the applicable levels of measurement and Payment Amounts are listed in Attachment 3. Any additional terms, conditions precedent and definitions, if applicable, for any Performance Guarantee, are listed in the applicable Attachment 3 subsection. In the event of a conflict between terms in the Agreement, the terms of the applicable Attachment 3 subsection shall control.
2. CHLIC will report to Employer on each Performance Guarantee (the "**Performance Reports**") within the specific time frame listed in the applicable Attachment 3 subsection for each specific Performance Guarantee.
3. Employer shall notify CHLIC in writing within sixty (60) days of receiving the Performance Report of any dispute concerning the Performance Report.
4. CHLIC or Employer, as applicable, shall pay any Payment Amount due within 60 days after performance results are provided to Employer for the applicable. Upon prior written notice to Employer, CHLIC may offset the Payment Amount against any payments owed by Employer to CHLIC.
5. In the event that Employer fails to perform any of its obligations under the applicable Service Agreements and/or Policies in a way that materially affects CHLIC's ability to perform a function being measured in a Performance Guarantee, CHLIC reserves the right to adjust the Payment Amount, if any, to account for Employer's act or omission.
6. Performance Reports measure results for the entire Guarantee Period. Any quarterly or other periodic results shared with Employer are for informational purposes only.
7. No third party audit results will be used to measure performance under a Performance Guarantee.
8. Payment Amounts are based on the Projected Population and/or total amount of fees expected to be paid by Employer to CHLIC under the applicable Service Agreements and/or Policies. Payment Amounts are subject to change by CHLIC in the event that the Projected Population and/or total amount of fees paid by Employer under the applicable Service Agreements and/or Policies during the Guarantee Period changes.

Section 5. – Measurement Methodology/Changes

1. CHLIC shall apply its standard methodology, consistent with applicable industry standards, to measure its performance under a Performance Guarantee. Additional information about methodology for specific Performance Guarantees, if applicable, is detailed in the applicable Attachment 3 subsection. Industry standard codes, including but not limited to CPT, ICD-10, NDC and CDT codes, that are set by the industry or a government agency are subject to update/change. Any such updates/changes occurring after the Effective Date will be deemed incorporated into this Agreement without further action required by the Parties except that CHLIC shall notify County of any such update/change.
2. CHLIC may replace or modify Performance Guarantees if necessitated by a change in the way CHLIC systematically tracks or measures the applicable performance guaranteed. Any substitute Performance Guarantee will, to the extent reasonably possible, attempt to reflect the same underlying objective and

performance level reflected in the original Performance Guarantee, consistent with its new measurement/tracking methodology. CHLIC shall explain the reasons for the change of a Performance Guarantee and the specifics of the substitute Performance Guarantee in writing at least 30 days prior to such change.

Section 6. – Modification of Agreement

Except, as otherwise provided herein, no modification or amendment hereto shall be valid unless in writing and agreed to by an authorized person of each of the Parties.

Section 7. – Choice of Law

1. This Agreement shall be interpreted and construed in accordance with the laws of the State of Florida. Any and all claims, controversies, and causes of action arising out of or relating to this Agreement, whether sounding in contract, tort, or statute, shall be governed by the laws of the State of Florida, including its statutes of limitations, without regard to any conflict-of-laws or other rule that would result in the application of the law of a different jurisdiction.
2. The Parties shall perform their obligations under this Agreement in conformance with all Applicable Laws and regulatory requirements.

Section 8. – 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:

1. 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.
2. In the event that a Controversy has not been resolved within thirty-five (35) calendar days of the request of Executive Review under Section 8.1., above, either Party may 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**") using American Arbitration Association mediators. 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. The Parties shall not, however, be required to mediate the Controversy.
3. 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 8.2. 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.

4. 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 other affiliates of Cigna Corporation, 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 other affiliates of Cigna Corporation. 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 8 shall survive the termination of this Agreement.

Section 9. – 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 10. – Assignment and Subcontracting

No assignment of rights or interests hereunder shall be binding unless approved in writing by a duly authorized officer of each of the Parties; 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 11. – Nondisclosure

Information CHLIC reports to Employer in connection with this Agreement, including the Performance Guarantee Reports and the Payment Amounts, are proprietary and confidential if protected from disclosure under specific Florida or Federal law which CHLIC shall identify for each type of information it wishes to prevent disclosure prior to the Agreement's effective date. Employer shall maintain the confidentiality of any statutorily protected information provided to Employer pursuant to this Agreement and shall not disclose statutorily protected information to any other party without the express written consent of CHLIC or as otherwise required by law. "**Contractor Confidential Information**" means any Contractor information that is designated as confidential and/or exempt by Florida's public records law, including information that

constitutes a trade secret pursuant to Chapter 688, Florida Statutes, and is designated in this Agreement or in writing as a trade secret by Contractor (unless otherwise determined to be a public record by applicable Florida law). Notwithstanding the foregoing, Contractor Confidential Information does not include information that: (i) becomes public other than as a result of a disclosure by the County in breach of the Agreement; (ii) becomes available to the County on a non-confidential basis from a source other than Contractor, which is not prohibited from disclosing such information by obligation to Contractor; (iii) is known by the County prior to its receipt from Contractor without any obligation or confidentiality with respect thereto; or (iv) is developed by the County independently of any disclosures made by Contractor.

Section 12. – No Waivers

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

Section 13. – 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 14. – 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 15. – Survival

Provisions contained in this Agreement that by their sense and context are intended to survive completion of performance, termination or cancellation of this Agreement shall so survive.

Section 16. – Force Majeure

CHLIC shall not 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 CHLIC or its affiliates or subcontractors, 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 CHLIC, its employees, officers, or directors, acts of God, fires, wars, accidents, labor disputes or shortages, and governmental actions, laws, ordinances, rules or regulations.

Section 17. – Notices

Except as otherwise provided herein, 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
8505 East Orchard Road

Greenwood Village, CO 80111
Attention: Chris Iseminger, Risk & Underwriting Senior Director

To Employer:
Pinellas County Board of Commissioners
400 South Ft. Harrision, 4th Floor
Clearwater, FL 33756
Attention: Kimberly Crum, Pinellas County Human Resources Director

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 18. – Entire Agreement

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

Section 19. – Independent Contractors

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

Section 20. – Reservation of Intellectual Property

Each Party reserves all right, title, and interest in and to its respective copyrights, patents, trade secrets, trademarks, and other intellectual property, whether presently existing or hereafter authored, invented, developed, or acquired. Without limiting the foregoing, as between the Parties, CHLIC shall solely and exclusively own the systems, methodologies, and technology used to provide the services, all modifications, enhancements, and improvements thereto, and all associated intellectual property rights. No rights or licenses are granted to Employer other than the limited right to receive and use the services under and in accordance with this Agreement. CHLIC shall own and be free to use and incorporate without payment or other consideration to Employer any ideas, suggestions, recommendations, or other feedback provided to

CHLIC in connection with its provision of the services. Nothing in this Agreement is intended or shall be construed to create any joint authorship, joint inventorship, or similar relationship or endeavor between the Parties.
The obligations set forth in this Section 20 shall survive termination of this Agreement.

Section 21. – 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, 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 21 shall survive termination of this Agreement.

Signatures

SIGNATURE AREAS HAVE BEEN INTENTIONALLY DELETED FROM THIS AGREEMENT

3.1 - Implementation

1. **Additional Definitions**

1.1. Commitment Dates – means the dates by which CHLIC must perform specific implementation services, as set forth in the Implementation Calendar.

1.2. Implementation Calendar – means the schedule that sets out the mutually agreed upon obligations for Employer and CHLIC in connection with the implementation of the Plan.

2. **Additional Conditions Precedent**

2.1. Benefit Profiles must be finalized and provided to CHLIC by Employer at least 60 days prior to the Effective Date or CHLIC confirms that the non-standard design and structure can be reasonably implemented at least 30 days prior to the Effective Date.

2.2. Employer or its designated agent must provide to CHLIC eligibility information for Plan Participants that is accurate, complete, accessible, and timely under the predetermined schedule.

2.3. The Implementation Calendar must be finalized and approved by Employer and CHLIC prior to the Effective Date.

2.4. Employer must fulfill its obligations in the Implementation Calendar, including timely, accurate and complete Plan Participant eligibility information and Benefit Profiles.

2.5. Employer must return the completed Account Implementation Survey within sixty (60) days of receipt, in accordance with paragraph titled “Overall Satisfaction with Implementation Services” below.

3. **Additional Terms**

3.1. The Guarantee Period for the Implementation Performance Guarantees is six (6) months beginning on the Effective Date.

3.2. Implementation Performance Guarantees set forth in this Exhibit shall be measured solely based on the timely, complete and accurate information provided by Employer or its designee to CHLIC as of the due dates set forth in the Implementation Calendar.

4. **Implementation Performance Evaluation Measures**

4.1. **Identification Card Delivery**

4.1.1. Identification Card Delivery – will be determined by whether CHLIC mailed identification cards to Plan Participants by the dates indicated in the Implementation Calendar.

4.2. **Claim Readiness**

4.2.1. Claim Readiness – will be determined by whether all complete and accurate Benefit Profile and eligibility information for each eligible Plan Participant under the Plan was loaded on CHLIC’s claims processing system as of the Commitment Date set forth in the approved Implementation Calendar.

4.3. **Call Readiness**

4.3.1. Call Readiness Performance – will be determined by whether Plan specifications were loaded into the applicable inquiry system with CHLIC ready to respond to Plan Participant inquiries as of the Commitment Date set forth in the approved Implementation Calendar.

4.4. **Overall Satisfaction with Implementation Services**

4.4.1. Overall Satisfaction with Implementation Services – will be determined by whether Employer is satisfied with the implementation process, as reflected by a score equal to or greater than the Implementation Satisfaction score indicated on Attachment 3 on the question “Overall, how satisfied were you with your most recent installation experience with Cigna?” in the Cigna HealthCare Implementation Survey to be distributed to the Employer by CHLIC. The Account Implementation Survey shall be provided to the Employer within sixty (60) calendar days after the Effective Date; the Employer shall return the completed Account Implementation Survey results to CHLIC within sixty (60) days of receipt.

5. **Evaluation of Performance and Payment Amounts**

5.1. Within four (4) months of completion of Implementation, CHLIC shall compile the necessary documentation and perform the necessary calculations to evaluate its fulfillment of each performance commitment set forth in this Agreement and any payments owed and make this information available to the Employer in a Performance Report.

3.2 - Service

1. **Additional Definitions**

1.1. Abandonment Rate – means the percentage of Calls received by the Special Accounts Queue resulting in the caller terminating the Call before speaking with a CSA.

1.2. Average Speed to Answer – means the sum of the total elapsed time between the moment when a Call is queued and the time the Call is responded to.

1.3. Call – means a telephone call received by the Special Account Queue from a member about a Claim or benefit provided by the Plan.

1.4. CHLIC's Standard Quality Assurance Audit Methodology – means the method by which CHLIC objectively measures claim quality by auditing claims to measure claim accuracy through identification of claim payment or processing errors that are based on data available to the claim processor at the time/day the claim was paid, that caused incorrect payment or correspondence that has a customer impact and that results in correctional work by CHLIC.

1.5. Claim – means a claim received by CHLIC for benefits under the Plan(s). If the term “claim” is used without a capital c, it refers to a claim received by CHLIC for benefits whether under the Employer’s Plan(s) or under other plans.

1.6. Claim Platform Level – means the performance commitment is measured using a random sample of all the claims processed on the same claim engine that processes the Employer’s Claims.

1.7. Customer Service Advocate (“CSA”) – means a person whose job it is to respond to Calls.

1.8. Inquiry – means an activity generated as a result of a Call received about a Claim or benefit matter. One Call may result in one or more activities.

1.9. Maintenance Eligibility – means additions, deletions and changes in eligibility that are processed during the Guarantee Period.

1.10. Maintenance ID Cards – means ID Cards issued during the Guarantee Period for changes in member address, changes in enrollment, etc.

1.11. Processed – means that CHLIC has made a determination as to whether expenses for which a Claim/claim is made are covered and, if covered, determined the amount of reimbursement or determined that the Claim/claim is missing critical data which must be requested from an external source.

1.12. Special Account Queue – means a group of CHLIC associates that handle a specific block of business with similar Average Speed of Answer and Abandonment Rate requirements. For measurement purposes, results are derived by compiling combined results for all accounts with this requirement.

2. **Performance Guarantee Metrics**

2.1. **Claim Time-to-Process (TTP)**

Claim Time-to-Process - will be calculated by counting the number of Business Days or calendar days (as appropriate as determined by CHLIC) from the day that a Claim is received by CHLIC to and including the day the Claim is Processed. The day that the Claim is received will not be included in this calculation.

2.2. Claim Quality

2.2.1. Financial Accuracy

2.2.1.1. Financial Accuracy - will be determined by applying CHLIC's Standard Quality Assurance Audit Methodology to a statistically valid sample of Claims (Account Level) or claims (Claim Platform Level) processed during the Guarantee Period.

Financial Accuracy represents the sum of the absolute value of total dollars overpaid and the total dollars underpaid subtracted from the total dollars paid, divided by the total dollars paid, expressed as a percentage. Overpayments and underpayments are determined from auditing a statistically valid sample of Claims/claims paid during the Guarantee Period.

In the event that an Account Level Financial Accuracy Performance Guarantee is applicable and Employer has fewer than 2,500 Employees enrolled in the Plan(s) on the Effective Date, CHLIC may charge Employer a reasonable administrative fee determined by CHLIC.

2.2.2. Claim Processing Accuracy (Overall Accuracy)

2.2.2.1. Claim Processing Accuracy (Overall Accuracy) - will be determined by applying CHLIC's Standard Quality Assurance Audit Methodology to a statistically valid sample of Claims (Account Level) or claims (Claim Platform Level) processed during the Guarantee Period.

Claim Processing Accuracy (Overall Accuracy) represents the total number of Claims/claims processed without any errors (both financial and non-financial errors) divided by the total Claims/claims processed, expressed as a percentage. The calculation of Claims/claims paid with error is determined from auditing a statistically valid sample of Claims/claims paid during the Guarantee Period.

In the event that an Account Level Claim Processing Accuracy (Overall Accuracy) Performance Guarantee is applicable and Employer has fewer than 2,500 Employees enrolled in the Plan(s) on the Effective Date, CHLIC may charge Employer a reasonable administrative fee determined by CHLIC.

2.2.3. Claim Payment Accuracy

2.2.3.1. Claim Payment Accuracy - will be determined by applying CHLIC's Standard Quality Assurance Audit Methodology to a statistically valid sample of paid Claims (Account Level) or claims (Claim Platform Level) processed during the Guarantee Period.

Claim Payment Accuracy represents the total number of Claims/claims processed without any payment errors, divided by the total Claims/claims processed, expressed as a percentage. The calculation of Claims/claims paid with financial error is determined

by CHLIC from auditing a statistically valid sample of Claims/claims paid during the Guarantee Period.

In the event that an Account Level Claim Payment Accuracy Performance Guarantee is applicable and Employer has fewer than 2,500 Employees enrolled in the Plan(s) on the Effective Date, CHLIC may charge Employer a reasonable administrative fee determined by CHLIC.

2.2.4. **Gross Adjustment Rate**

Gross Adjustment Rate – will be determined by dividing the total number of adjusted Claims processed during the Guarantee Period by the total Claims processed during the Guarantee Period, expressed as a percentage. Adjusted Claims are Claims reopened and corrected after the initial adjudication or processing, excluding adjustments solely due to decisions made by Employer.

2.3. **Inquiry**

2.3.1. **Average Speed of Answer (ASA)**

2.3.1.1. ASA - will be determined by measuring the sum of the total elapsed time between the moment when a Call is queued and the time the Call is responded to for all answered Calls, and then dividing that number by the total number of Calls answered during the Guarantee Period.

The calculation of ASA is based on all Calls received during the hours of operation during the Guarantee Period that are serviced in the Special Account Queue.

2.3.2. **Call Abandonment Rate**

2.3.2.1. Call Abandonment Rate - will be determined by dividing the total number of Calls received during the Guarantee Period that result in the caller terminating the Call after it is queued to a CSA, by the total number of Calls received during the Guarantee Period, expressed as a percentage.

The calculation of Call Abandonment Rate is based on all Calls received during the hours of operation during the Guarantee Period that are serviced in the Special Account Queue.

2.3.3. **First Call Resolution**

2.3.3.1. First Call Resolution Rate - will be determined by dividing the number of first Calls without a repeat Call during the Guarantee Period by the total number of original unique Inquiries received during the Guarantee Period, expressed as a percentage. A Call will be considered a “first Call without a repeat Call” if there is not a Call involving the same matter during the 45 day period prior to the Call or during the 45 day period following the Call.

2.3.4. **Call Activity Closure Rate**

2.3.4.1. Call Activity Closure Rate - will be determined by dividing the number of Inquiries closed within the Guarantee Period by the total number of Inquiries received during the Guarantee Period, expressed as a percentage. An Inquiry will be considered closed when CHLIC gives it a closed status on its Inquiry Tracking System(s). The Call Activity Closure Rate will be calculated by counting the number of Business Days from the Business Day that the Inquiry is received, to and including the Business Day that the Inquiry is closed. For purposes of this calculation, the Business Day that the Inquiry is received will not be included in the calculation.

2.3.5. **CSA Quality**

2.3.5.1. CSA Quality Rate - will be determined by averaging the quality scores of randomly monitored answered Calls at the Account Level or Book of Business during the Guarantee Period, expressed as a percentage. The average quality score of randomly monitored answered Calls at the Account Level or Book of Business during the Guarantee Period shall achieve CHLIC's quality standards.

2.4. **Employer Service**

2.4.1. **Automated Maintenance Eligibility Processing***

*This Performance Guarantee shall not apply if Employer is using the Enrollment Maintenance Tool.

2.4.1.1. Additional Condition Precedent - This Maintenance Eligibility Processing Performance Guarantee is contingent upon the submission by Employer (or Employer's agent) of full electronic eligibility files containing no more than two (2) percent erroneous records. An "erroneous record" means any Plan Participant record lacking any of the accurate information necessary to correctly administer benefits, such as: correct spelling of the Plan Participant's name; applicable Social Security Number; date of birth; account number; division (if any); branch number; information to correctly identify plan and benefit structure, such as benefit option code, benefit structure, plan code, plan type, network ID (if the Plan uses provider networks); effective date of coverage; termination date; HIPAA privacy information (if any); member address and any other demographic data.

2.4.1.2. Maintenance Eligibility Processing - will be determined by dividing the number of eligibility files that met the performance standard during the Guarantee Period by the total number of eligibility files processed during the Guarantee Period, expressed as a percentage. Whether the performance standard has been met will be determined by counting the number of Business Days from the Business Day that the file is received by CHLIC to and including the Business Day the file is entered into the CHLIC eligibility system. The Business Day the file is received will not be included in this calculation.

2.4.2. **Maintenance ID Cards**

2.4.2.1. Maintenance ID Cards - performance will be determined by dividing the number of ID cards that were issued to Plan Participants within the designated number of Business Days during the Guarantee Period by the total number of ID cards issued to Plan Participants during the Guarantee Period, expressed as a percentage. For purposes of this calculation, whether an ID card was issued to a Plan Participant within the designated number of Business Days will be determined by counting the number of Business Days from the Business Day that eligibility information necessary to issue the ID card is released to the ID card vendor, to and including the Business Day that the ID card is issued to the Plan Participant. The Business Day the eligibility information is received by the ID card vendor will not be included in this calculation.

2.5. **Account Management**

2.5.1. Account Management Performance Guarantee – will be met if CHLIC's Account Management Sales Team provides services to Employer of such quality that the designated Account Management Composite Score based upon four (4) quarterly scorecards during the Guarantee Period is met on the Account Management Report Card (sample available upon request).

2.5.2. Account Management Condition Precedent – This commitment is contingent on Employer completing its obligations in the "Evaluation of Account Management" subsection below, on a quarterly basis.

2.5.3. Evaluation of Account Management - At the beginning of the Term, Employer shall designate individuals on its benefits staff who will receive and complete the Account Management Report Card on a quarterly basis.

The Account Management Report Card will be distributed to Employer's designated staff members on a quarterly basis, shall be completed, signed and dated by them, and all returned to CHLIC by Employer within three (3) weeks of the distribution date. Failure of Employer to meet its obligations in this subparagraph and the subparagraph above shall nullify the Account Management Performance Guarantee.

Following the end of the Guarantee Period and receipt of the fourth (4th) quarterly Report Card from Employer, CHLIC will calculate the composite score in each performance assessment category by averaging the scores for the four (4) quarters of the Guarantee Period. The assessments of each of the designated staff members and each of the performance assessment categories will be weighted equally. The Account Management Performance Guarantee will be deemed fulfilled if the average of the composite scores in each category ("Account Management Composite Score") is equal to or greater than the Account Management Composite Score indicated on Attachment 3.

2.5.4. Reservation of Right – CHLIC reserves the right to make changes during the Term in its staff/personnel assigned to provide Account Management services to Employer.

3. **Evaluation of Performance and Payment Amounts**

3.1. Within four (4) months after the end of the Term, CHLIC shall compile the necessary documentation and perform the necessary calculations to evaluate its fulfillment of each Performance Guarantee set forth in this Agreement and make this information available to Employer in a Performance Report.

The Payment Amounts in Attachment 3 have been established in relationship to the Projected Population. In the event that the actual number of Employees enrolled on the Effective Date is greater than one-hundred and fifteen percent (115%) of the Projected

Population, the Employer reserves the right to increase the Payment Amounts in proportion to the variation between the actual and projected number of enrolled Employees. Correspondingly, CHLIC reserves the right to decrease the Payment Amounts in proportion to the variation between the actual and projected number of enrolled Employees in the event that the actual number of Employees enrolled on the Effective Date is less than eighty-five percent (85%) of the Projected Population.

3.3 - Your Health First (YHF)
Table 1 – Guarantee Details

PERFORMANCE GUARANTEES Your Health First®			
ENGAGEMENT **Client-Specific Reporting**	**PAYOUT SCHEDULE**	**Client Req'ts**	**Availability**
Customer Health Engagement - 15% of Total Population will complete at least 2 Health Maintenance actions, or 1 Health Improvement Action	14.9% - 12.0% - 25% payout 11.9% - 9.0% - 50% payout 8.9% - 6.0% - 75% payout <6.0% - 100% payout	a, b, c	i
RISK			
30% of YHF Fees at Risk on Engagement Metric			

CLIENT REQUIREMENTS
a) 80% Valid Phone Numbers
b) 80% Valid Email Addresses
c) Standard Product Design

AVAILABILITY
i) Available all program years

Additional Definitions

1.1. Baseline Period – typically means the twelve (12) month period immediately prior to effective date of the applicable Guarantee Period. CHLIC reserves the right to re-establish the Baseline Period as applicable to the particular Performance Guarantee as determined by CHLIC.

1.2. Book of Business - means that performance will be based upon the results of Your Health First programs administered by CHLIC or an affiliate for Employer and all other Your Health First program clients. Results will be reported on a calendar year basis only.

1.3. Book of Business Claim Costs - means all fee-for-service (and fee-for-service equivalents for capitated encounter data) health care costs (including all pharmacy costs) incurred on a Cigna Book of Business basis for Cigna Book of Business Covered Services on Plan Participants during the applicable period (i.e., Baseline Period or Guarantee Period) capped at $100,000 per Plan Participant. "Claims Costs" do not include any Plan Participant co-payments, coinsurance or deductible amounts or any Your Health First Program charges paid by the Employer. For purposes of this definition, a cost is "incurred" on the date that a Covered Service is provided to a Plan Participant not the date the Plan pays the cost.

1.4. Book of Business Covered Services - means health care (including pharmacy) services and/or supplies that are covered under all medical Plans administered by CHLIC or an affiliate for clients who have implemented Your Health First.

1.5. Client Specific –means that CHLIC's performance is measured for the Guarantee Period based only upon Employer's Plan Participants, not the Cigna Book of Business performance.

1.6. Client Specific Claim Costs - means all fee-for-service (and fee-for-service equivalents for capitated encounter data) health care costs (including all pharmacy costs) for Client Specific Covered Services incurred under Employer's applicable Plan(s) during the applicable period (i.e., Baseline Period or Guarantee Period) subject to a cap as reflected in Table 2. "Claims Costs" do not include any Plan Participant co-payments, coinsurance or deductible amounts, or any Your Health First Program charges paid by the Employer. For purposes of this definition, a cost is "incurred" on the date that a Covered Service is provided to a Plan Participant not the date the Plan pays the cost.

1.7. Client Specific Covered Services- means health care (including pharmacy) services and/or supplies that are covered under Employer's applicable Plan(s).

1.8. Fees at Risk – unless otherwise indicated in this Attachment 3 subsection, means the portion of Your Health First fees that will be used to calculate the amount that either Party may be required to pay the other under this Performance Guarantee**.**

1.9. Health Maintenance Action –means actions to maintain health, protect or improve health or detect illness. (Detailed list available upon request.)

1.10. Health Improvement Action – means actions to manage and improve current illness/condition. (Detailed list available upon request.)

1.11. Your Health First (YHF) Program - means a program that provides holistic support to Plan Participants with chronic conditions, combining medical and lifestyle support to meet the needs of each Plan Participant.

2. **Additional Terms and Conditions Precedent**

2.1. Plan Participants must be continuously enrolled in the Plan(s) to which this Performance Guarantee applies for at least six (6) months to be included in the measurement.

2.2. If Employer cancels or discontinues Cigna Pharmacy coverage during the Guarantee Period, the Engagement guarantee target will be lowered by 20%.

2.3. At all times during the Guarantee Period, the Plan(s) to which this Performance Guarantee applies must include core medical management services administered by CHLIC and/or its affiliates including, at a minimum, pre-certification requirements, continued stay review services and case management services.

2.4. Employer must make available to CHLIC required historical medical claim data, pharmacy claim data, and eligibility data with respect to the ROI Baseline Period. If Employer is new to CHLIC, then prior to the Effective Date it must also complete the claims based “jumpstart” process which combines historical medical claim data, pharmacy claim data, and eligibility data for the ROI Baseline Period with current eligibility information.

2.5. For existing clients CHLIC will use appropriate historical pharmacy claim data, historical medical claim data, and historical lab results claim data. For new clients, CHLIC will use appropriate claims based “jumpstart” data, historical pharmacy claim data, historical medical claim data, and historical lab results claim data provided by Employer or Cigna Book of Business as determined by CHLIC to measure the ROI Baseline Period result.

2.6. All additional requirements reflected in Table 1 of this Attachment must be in place and effectively measured.

2.7. CHLIC shall not be obligated to provide the Client Specific Clinical Performance Guarantees if:

2.7.1. The number of Employees enrolled on the Effective Date is less than 85% of the Projected Population;

2.7.2. There is a 20% or greater turnover in Plan Participants during the Guarantee Period;

2.7.3. Employer has provided to CHLIC valid phone numbers for 80% of Plan Participants to whom CHLIC makes an outreach attempt during the Term of the Agreement as part of the Your Health First program. Employer has included email addresses for at least 80% of subscriber records in eligibility files within 30 days after the Effective Date of the Agreement;

2.8. As noted in Table 1 of this Attachment, certain metrics are subject to a “minimum qualifying” rule of 100 Plan Participants. If less than 100 Plan Participants are in the denominator of a metric, then CHLIC will blend the Client Specific result with the Cigna Book of Business result.

2.9. If Employer is a new CHLIC customer, the first Guarantee Period for any Clinical Compliance performance guarantee will be the second year of the applicable program(s).

2.10. CHLIC's recommended means of engagement outreach (i.e., telephonic, online, letters, text message, etc.) is used. If client elects not to implement CHLIC's recommended means of engagement outreach, CHLIC reserves the right to revise the performance guarantee.

2.11. CHLIC may remove from the calculations any data it concludes to be incomplete or not credible.

3. **Engagement Guarantee Evaluation Metrics**

3.1. Cigna Health Matters Engagement Index – The number of Plan Participants that complete at least two Health Maintenance Actions or at least one Health Improvement Action during the Guarantee Period will be divided by the total number of Plan Participants to determine whether the target percentage of Plan Participants engaged in Health Maintenance Actions or Health Improvement Actions is met. If there is an increase of 10% or more in the number of Plan Participants in the last six months of the Guarantee Period, all such Plan Participants will be excluded from the calculation.

4. **Member Satisfaction Guarantee Evaluation Metrics**

4.1. Member Satisfaction – Cigna shall survey a sampling of individuals who have completed two or more coaching calls with Your Health First. Cigna shall measure results on a monthly basis to determine the number of individuals who answer "Very Satisfied" or "Satisfied" to the following survey question: "Please rate your overall satisfaction with the services from your Personal Health Team", divided by the total number of responses, expressed as a percentage. Results are determined on a Cigna Book of Business basis.

5. **Evaluation of Performance and Payment Amounts**

CHLIC shall pay any amounts due under this Agreement within sixty (60) days following delivery by CHLIC of the Performance Report. Client Specific reporting will be provided for Employer's Guarantee Period. Book of Business reporting will be provided on a calendar year basis only.

3.4 - Integrated Advocacy Return on Investment (ROI) Guarantee

Integrated Advocacy – One Guide with HMCM ROI – every $1.00 spent on the OneGuide and HMCM programs during the Guarantee Period will result in a $4.00 savings in plan benefit costs during the Guarantee Period. Results will be reconciled based on the Activity Based Methodology outlined in Table 1 utilizing Client Specific data.

1. **Additional Definitions**

1.1. Agreement Term – means the twelve (12) month period commencing on the effective date of this Agreement.

1.2. Client Specific – means that CHLIC's performance will be measured for the Guarantee Period based upon the results of the OneGuide & HMCM program administered by CHLIC or an affiliate for Employer, not the Cigna Book of Business Level.

1.3. Guarantee Period – means the twelve month period from January 1, 2022 to December 31, 2022 inclusive.

1.4. Integrated Advocacy – an integrated approach of capturing all the benefits/savings resulting from steerage, use of CHLIC and its affiliates' tools and services as well as connecting to Cigna clinical programs. See Table 1 for more detailed description of all savings captured as part of Integrated Advocacy.

1.5. Health Matters Care Management (HMCM) – (as referred to in Attachment 3 subsection) – a CHLIC medical management program consisting of:

- Designated clinical delivery team,
- Inpatient pre-certification of coverage,
- concurrent review,
- discharge planning,
- retrospective review,
- short-term and long-term case management,
- continued stay review,
- inpatient case management beginning on the first day of hospitalization, and
- outpatient pre-certification for a defined list of outpatient procedures and services.

1.6. Health Information Line – a CHLIC program that assists individuals in understanding the right level of treatment at the right time. Clinicians are available 24/7/365 to provide health and medical information and guidance to the most appropriate resource for immediate care needs, while leveraging benefits and cost considerations.

1.7. Gaps in Care – a CHLIC Well Informed Gaps in Care program that proactively addresses deficiencies, gaps and omissions in an individual's care.

1.8. Return on Investment (ROI) – means the ratio determined by dividing the sum of the Plan's cost savings per employee per month realized during the Guarantee Period as the result of the Integrated Advocacy approach by the total cost for One Guide & HMCM incurred per employee per month by the Employer during the Guarantee Period.

Return on Investment = Guarantee Period Savings per employee per month
Guarantee Period Program Fees per employee per month

2. **Additional Conditions Precedent**

2.1. If Employer cancels or discontinues Cigna Pharmacy Health coverage during the Guarantee Period, the guarantee target will be lowered as deemed appropriate in Cigna's sole discretion.

2.2. This performance guarantee does not apply and no payment shall be made by CHLIC unless:

2.2.1. At all times during the Guarantee Period, Employer has One Guide and the HMCM program in effect.

2.2.2. A minimum of 1,500 employees are enrolled in the program for the entire Guarantee Period

2.2.3. Employer has provided to CHLIC valid phone numbers for 80% of Plan Participants to whom CHLIC makes an outreach attempt during the Term of the Agreement as part of the HMCM program. Employer has included email addresses for at least 80% of subscriber records in eligibility files within 30 days after the Effective Date of the Agreement.

3. **Evaluation & Penalty Payment**

3.1. If the target set forth in Attachment 3 is not met, CHLIC shall pay Employer a penalty determined in accordance with Attachment 3.

Within twelve (12) months following the end of the Guarantee Period, CHLIC shall provide to Employer results of its performance during the Guarantee Period and shall pay or credit to Employer any amounts payable under this Attachment within sixty (60) days following delivery by CHLIC of the results to Employer.

Table 1 - Activity Based Savings Methodology for Integrated Advocacy

Pre-Certification:
Savings are estimated based on the average cost of the services avoided as a result of denials of authorizations for medically unnecessary services/items and the average number of days associated with the avoided services during the Guarantee Period. If a pre-certification denial is overturned on appeal, the savings for the services are adjusted accordingly.

Inpatient Case Management:
Guiding to Higher Performing Providers:

- Steerage to Higher Performing Providers: customers who have interacted with Cigna (via phone or myCigna.com/mobile) and have subsequently formed a new relationship with a Cigna Care Designation (CCD) provider. Client Specific difference between episodes costs of CCD is accounted for in savings
- Steerage to Centers of Excellence (COE): customers who have interacted with Cigna (via phone or myCigna.com/mobile) and have subsequently gotten care/procedure at a COE. Client Specific difference between episodes costs of COE is accounted for in savings

Choosing Lower Cost Settings:

- Identifying customers who have opportunity to be steered to an in-network provider due to prior out of network utilization. Savings account for all customers who have interacted with Cigna (via phone or myCigna.com/mobile) and subsequently went to an in-network provider based on average savings of in-network steerage
- ER steerage includes Client Specific redirect savings (ER cost per visit minus Urgent Care cost per visit) for all customers post interaction with Cigna via phone or myCigna.com/mobile app.
- Preferred Lab steerage identifies customers who have an opportunity to be steered and are provided lab usage guidance when customer interacts with Cigna via phone or myCigna.com/mobile. Every customer who following the interaction has a visit with a preferred lab is counted towards the savings.
- Virtual Care savings includes a distinct count of customers who had a telehealth visit in the reported period, after having a prior telephonic/digital interaction with Cigna looking back 24 months. Savings based on average savings.
- Clients with Pharmacy benefit also have the following savings accounted for (when applicable):
    - Savings from customers who switch from brand to generic medication
    - Savings from customers who switch from non-preferred brand of medication to a preferred brand
    - Savings from customers who switch to 90 day medication fulfillment through Cigna 90 Now

Connecting Customers to Health Improvement Programs:

- Cigna's Health Information Line (HIL): HIL provides guided support to customers on various topics. Savings associated with each call are accounted for in Client Specific savings.

- Gaps in Care Closures: Total number of credited (Cigna Health Advocacy program) gaps in care closures

HMCM Specific Savings:

Pre-Certification:

Savings are estimated based on the average cost of the services avoided as a result of denials of authorizations for medically unnecessary services/items and the average number of days associated with the avoided services during the Guarantee Period. If a pre-certification denial is overturned on appeal, the savings for the services are adjusted accordingly.

Inpatient Case Management:

Savings are estimated based on:

- the average cost of the inpatient bed days avoided following admission to a facility as a result of denials for medically unnecessary hospital days through the concurrent stay review process;
- the average cost difference in bed type avoided through steerage to medically appropriate intensity or bed type (e.g., ICU vs. Med/Surge bed); and
- the average cost of projected readmissions that are avoided.

Case Management:

Savings reflect CHLIC's best estimate of the claim savings achieved as a result of medical management interventions. The results reported are based upon information from medical management authorization data and are not validated against claims experience. Often amounts reported as savings are based upon population-based savings estimates and projections.

- **Facilitating Transfers to Appropriate and Cost-effective Level/Setting of Care:**

Savings reflect CHLIC's best estimate of claim savings achieved as a result of CHLIC's case managers:

- facilitating outpatient care for Plan Participants receiving care as an inpatient where medically appropriate (as determined by the Plan Participant's treating physician);
- facilitating acute care or sub-acute level of care for Plan Participants in an Intensive Care Unit (ICU) where appropriate (as determined by the Plan Participant's treating physician);
- facilitating sub-acute or skilled nursing facility care for Plan Participants receiving inpatient acute care.

The level and setting of care must always be determined by the attending physician, be medically appropriate, and not compromise the health of the Plan Participant.

- **Negotiating Discounts**:

Savings reflect claim savings achieved as a result of CHLIC Case Managers negotiating discounts for inpatient or outpatient services with non-participating providers.

- **Transitioning Participants to Participating Providers for Care**:

Savings reflect claim savings achieved as a result of CHLIC Case Manager persuading a Participant to use a Participating Provider for his/her care.

3.5 - Trend

1. **Additional Definitions**
   1.1. Covered Charges – The charges (including capitation payments) submitted for reimbursement under the Plan for Covered Services provided to Plan Participants. For purposes of clarification, the "Covered Charge" represents the total amount payable both by the Plan and the Plan Participants (e. g., for deductible, coinsurance, or copayment) for a particular Covered Service.
   1.2. Baseline Period – The 2021 calendar year.
   1.3. Guarantee Period – the 2022 calendar year.
   1.4. Plan - The program of medical welfare benefits which Employer has adopted for its Plan Participants (excluding Retirees who are 65+) and which is administered by CHLIC. The term "Plan" shall include each change, as of its effective date, which has been adopted by Employer and accepted by CHLIC as compatible with its guarantee obligations hereunder. Such adoption and acceptance shall be documented in writing and executed by an authorized officer of each of the Parties.
   1.5. 2022 Trend Target – 0.0%.
   1.6. Risk-Free Corridor – 0.0%.
2. **Additional Conditions Precedent**
   2.1. The average number of covered employees enrolled in the Plan throughout the Guarantee Period is not less than eight-five percent (85%) of the projected employee population of 3,255.

   2.2. The following Cigna programs must be purchased, implemented, and remain in place throughout the Guarantee Period:

   - HMCM Preferred
   - Your Health First 200
   - Premium PHT (Personal Health Team)
   - Cigna Pharmacy
   - Cigna Dental
   - Comprehensive Oncology
   - Healthy Pregnancies/Healthy Babies
   - Lifestyle Management (Weight Management and Stress Management)
   - One Guide
   - Cigna Total Behavioral Health
   - Motivate Me Engage

   2.3. CHLIC's obligation to pay any amount to Employer pursuant to this Agreement is conditioned upon the Service Agreements and/or Policies to which this Agreement relates being in full force and effect at the time a payment is due. No amount, otherwise payable to Employer, shall be payable to Employer pursuant to this Agreement following the termination of the Service Agreements and/or Policies to which this Agreement relates regardless of whether the term specified herein ended prior to or at the same time as termination of such Service Agreements and/or Policies.

2.4. The additional conditions/caveats, if any, set forth in Table 1.

3. **Additional Conditions of Guarantee**

3.1. This Trend Performance Guarantee agreement and the calculations herein do not apply to:

3.1.1. charges for services/supplies that are not reimbursed by the Plan for any reason;

3.1.2. any Covered Charges with respect to persons on COBRA coverage and retirees covered by Medicare and for whom Medicare is the primary payor;

3.2. CHLIC may adjust the Covered Charges in both the Baseline and Guarantee Period for the following:

- Any change in any federal, state or local legislation or regulation that (a) impacts CHLIC's ability to enter into Participating Provider Agreements, or (b) affects the Covered Charges.
- Cost changes due to macroeconomic variables outside of Cigna's control greater than 1% based upon the experience of Cigna's entire book of business or based upon a determination by an independent party.
- Covered Charges with respect to Plan Participants whose claims incurred in the Guarantee Period exceed $100,000;
- Changes in the composition of the Plan Participants with respect to age, gender, and employee to dependent ratios as measured from January 1, 2022 to December 31, 2022 or other dates as mutually agreed upon.
- Changes in enrollment as measured from January 1, 2022 to December 31, 2022 (or other dates as mutually agreed upon) that affect the geographic factor used by CHLIC in calculating the Trend Target.
- Changes in the Plan's benefit design.
- Changes in the Employer's contribution strategy.

4. **Performance Guarantee & Calculation Methodology**

4.1. Guarantee – CHLIC shall pay to Employer in accordance with the Payout Schedule in Section 4.3 based upon the 2022 Trend Achieved as compared to the 2022 Trend Target.

4.2. Calculation of 2022 Trend Achieved –

STEP 1: CHLIC shall calculate the "Trend Achieved" during the Guarantee Period. For purposes of this provision, the "Trend Achieved" is the percentage change in the average Covered Charges per Plan Participant for the Guarantee Period as compared to the average Covered Charges per Plan Participant for the Baseline Period calculated in each case using Covered Charges incurred during the applicable period and paid by the Plan through the third month following the applicable period. For purposes of illustration, the 2022 Trend Achieved for a calendar Plan year will be determined based upon Covered Charges incurred during calendar year 2022 and paid through March 31, 2023.

STEP 2: If the Trend Achieved is greater than the 2022 Trend Target, the adjustments specified in Section 3.2. will be made to the 2022 Trend Target.

4.3. Payout Schedule - If the 2022 Trend Achieved is more than the 2022 Trend Target, CHLIC will pay Employer in accordance with the schedule below.

Trend Achieved			Payout (PEPM)
0.0%	to	0.0%	$0.00
0.01%	to	1.00%	$2.00
1.01%	to	2.00%	$4.00
2.01%	to	3.00%	$6.00
>3%			$6.00

5. **Evaluation of Performance and Payment Amounts**

CHLIC shall provide a report of its performance with respect to the Trend Achieved (the "Performance Report") to Employer within nine (9) months following the end of the Guarantee Period. CHLIC shall pay any amounts due under this Agreement within sixty (60) days following delivery by CHLIC of the Performance Report.

Table 1 – Trend Guarantee Summary

To affirm Cigna's commitment to reducing medical costs and improving the health of your workforce, Cigna is guaranteeing Pinellas County BOCC a medical trend of 0.0%, supported by over $234,360 at risk.

Trend Summary

Medical Guaranteed Trend

Cigna Base Trend	**8.9%**
Total Cost Management	**-4.4%**
Unit Cost Position	
Benefit Optimization	
Clinical Excellence	**-5.2%**
Medical Management	
Health Advocacy	
Disease Management	
Condition Management	
Integration Value	**0.8%**
Pharmacy	
Pinellas County BOCC Guaranteed Trend	**0.0%**

Payout Schedule

Trend Achieved			Payout (PEPM)
0.0%	to	0.0%	$0.00
0.01%	to	1.00%	$2.00
1.01%	to	2.00%	$4.00
2.01%	to	3.00%	$6.00
>3%			$6.00

Commentary

Guarantee Overview: 17% of Total Fees at Risk

- This document outlines the performance results that Cigna is committed to delivering to Pinellas County BOCC, as well as, associated fees at risk. Cigna is guaranteeing a trend of 0.0% with a 0.0% corridor and a maximum of $6.00 PEPM fees at risk or $234,360
- The core components of the guarantee correspond to the program offering quoted by Cigna. Programs illustrated above are assumed to be implemented for Pinellas County BOCC
- The trend guarantee is illustrative, and does not serve as a binding agreement; if selected Cigna will construct a formal contract. This document is designed to outline the parameters and methodology for a trend guarantee in the first policy year with Cigna.

Reconciliation:

- Amount at Risk - this guarantee is a one-way trend guarantee with a 0.0% corridor, payout steps noted above, with a maximum payout of $6.00 PEPM
- This guarantee will be reconciled on a total spend (plan spend = employer spend + employee spend) basis.
- The guarantee will be considered met if a trend of 0.0% is achieved; if not, the determination of the payout will be adjusted for:
  - > claimants greater than $100,000
  - > demographic changes from 2021-2022
  - > geographic factors that change from 2021-2022
- Unforeseen macro cost changes may require an adjustment of macro trend to this guarantee. Changes to macro trend will be discussed with Pinellas County BOCC prior to any adjustments.
- Guarantee as constructed assumes a constant member cost share percentage. Cigna will calculate the year over year cost share differences by assessing 2021 carrier benefit designs vs finalized 2022 plan designs
- Unforeseen macro changes may require an adjustment of macro trend for 2022 within the guarantee. Changes to macro trend will be discussed with Pinellas County BOCC prior to any adjustments. Cigna agrees to the concept of a 3rd party index (Milliman Health Cost Index) and limit the movement of starting point trend for 2022 to scenarios in which trend varies by +/- 2.0% from current macro economic trend.

Requirements:

- Baseline Trend: Trend will be assessed on incurred claims for 2021 with three months of run out and incurred claims for 2022 with three months of run out. The 2022 incurred claims are to be provided in the format described on the attached 'Data Request' exhibit. If this baseline claim data is not received within six months of the plan effective date, this guarantee is null and void.
- Historical paid claims from the current self-insured carrier will be provided in accordance with Cigna's 'Jump Start' program in order to identify prior to December 15 2021 any members requiring case and disease management. Late receipt of this information will alter the trend deflection credits.
- Guarantee proposal targets a minimum valid phone number rate of 80%. As such, Pinellas County BOCC agrees to provide Cigna with updated phone numbers. Updated phone numbers will be provided through the eligibility file process and assessed quarterly for 'accurate numbers'
- Pinellas County BOCC agrees to achieve Health Risk Assessment completion rates of 35% for employees and spouses with at least 80% completed online.
- A communication strategy is necessary to ensure initial and continued success in the programs. Pinellas County BOCC will inform its members of the importance of the risk assessments as well as engagement in the new programs. Cigna will partner with Pinellas County BOCC to ensure success of the strategy.

Assumptions:

- Guarantee assumes the following:
  - > Illustrated guarantee and payout is based on 3,255 employees.
  - > Cigna is the exclusive carrier
  - > No Outpatient precertification occurs today
- Guarantee assumes Medical & Phamaracy are bundled
- Guarantee assumes existing product package remains in place
- The guarantee excludes any fees, State surcharges / assessments, or taxes paid through the bank account.

Attachment 4 – 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 Audit objectives;

   c. the scope of the Audit (time period, lines of coverage and number of claims);

   d. the process by which claims will be selected for audit;

   e. the records/information required by the Auditor for purposes of the Audit; and

   f. the length of time contemplated as necessary to complete the Audit.

2. Review of Specifications

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

3. Access to Information

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

4. Audit Report

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

5. Comment on Audit Report

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

6. Confidentiality

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

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

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

7. Restricted Use of the Audit Information

With respect to persons other than the Employer, the Auditor will hold and treat information obtained from CHLIC during the Audit with the same degree and standard of confidentiality owed by the Auditor to its clients in accordance with all applicable legal and professional standards. The Auditor shall not, without the express written consent of CHLIC executed by an officer of CHLIC, disclose in any manner whatsoever, the results, conclusions, reports or information of whatever nature which it acquires or prepares in connection with the Audit to any party other than the Employer except as required by applicable law. The 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:_____

Attachment 5 – 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.

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.

Attachment 6 – Stoploss Application

Application for Stop Loss Coverage

Cigna Health and Life Insurance Company
Mailing Address: Attn: Stop Loss Unit - B2STL
900 Cottage Grove Rd.
Hartford, CT 06152

The Applicant, whose representative has signed below, hereby applies to Cigna Health and Life Insurance Company ("Cigna") for a stop loss insurance policy(ies) providing the insurance coverage as described below in connection with its self-funded health benefit plan.

1. NAME OF APPLICANT: **Pinellas County Board of Commissioners**

ADDRESS: 400 South Ft Harrison, 4th Floor, Clearwater, FL 33756

2. AFFILIATED COMPANIES TO BE COVERED: _____

Name	*Address (City and State)*

Affiliated companies must be part of a common control group as described in Internal Revenue Code §414(c) and the regulations thereunder. Generally, this means that in a parent-subsidiary relationship, the parent must own 80% or more of the subsidiary. In a brother-sister relationship, the same five or fewer people must own at least 80% or more of each company and when considering the smallest percentage interest each person has among the companies, the sum of the smallest interests must exceed 50%. The purpose of this rule is to prevent covering a multiple employer welfare arrangement (MEWA). Any MEWA that wishes to be covered must provide evidence that state law in each jurisdiction in which it has persons to be covered allows the MEWA to operate on a self-insured basis.

3. NUMBER OF EMPLOYEES AT ALL LOCATIONS LISTED ABOVE: **3255**

INDUSTRY: **9199-General Government**

4. NAME OF CLAIM ADMINISTRATOR: **Cigna Health and Life Insurance Company**

ADDRESS: 900 Cottage Grove Road, Hartford, CT 06152

5. PROPOSED EFFECTIVE DATE: **01/01/2022**

6. ☒ INDIVIDUAL STOP LOSS COVERAGE

Benefits covered by Individual Stop Loss Coverage:

☒ Medical ☒ Mental Health/Substance Use Disorders ☒ Pharmacy

☐ Other: _____

PRODUCT FEATURES FOR INDIVIDUAL STOP LOSS COVERAGE:

☐ Tiered Pooling:
High Pooling Point $_____ Low Pooling Point $_____
Cigna Liability Split_____%
Applies to: ☐ All Claimants ☐ First_____Claimants

☐ Renewal Planner

☐ Renewal Advantage

☐ Bridge:
- ☐ ASO to ASO Bridge
- ☐ ASO to Shared Returns Bridge

☐ Other: _____

INDIVIDUAL STOP LOSS LIMIT: $ 550,000.00

High Risk Individuals:

☒ N/A

☐ Yes, individual(s) will be treated as follows:

☐ A separate Individual Stop Loss Limit Applies: $_____

☐ Other:_____

MAXIMUM LIFETIME REIMBURSEMENT LIABILITY

FOR INDIVIDUAL STOP LOSS: will be the individual lifetime maximum as set forth in the Benefit Plan less the Individual Stop Loss Limit or will be $____

BENEFIT PERCENTAGE PAYABLE:

100

% BENEFIT ELIGIBILITY BASIS:

Initial Policy Period: 01/01/2022 to 12/31/2022

Unless additional options are selected below, claims must be both Incurred and paid during the policy period.

☐ Incurred in_____months

☐ Paid in 12 months (available only for previously Cigna administered customers)

Run-In Provision: Claims Incurred prior to the policy's Effective Date and paid during the policy period.

☐ N/A ☒ 12 months

☐ Run-In claims are limited to: $_____[per individual]

Run-Out Provision: Claims Incurred during the policy period and paid after termination of the policy.

☒ N/A ☐ _____months

☐ OTHER REQUESTED PROVISIONS: _____

ESTIMATE MONTHLY INDIVIDUAL PREMIUM RATES*

Product/Benefit Option	*PEPM Rate*	*Product/Benefit Option*	*PEPM Rate*
Open Access Plus	$ 36.03	$	
HSA OpenAccess Plus	$ 36.03	$	
$		$	
$		$	
$		$	
$		$	

* Actual Rates will be contained in the Stop Loss Policy, if and when issued.

COMMENTS

7. ☐ AGGREGATE STOP LOSS COVERAGE

Benefits covered by Aggregate Stop Loss Coverage:

☐ Medical ☐ Mental Health/Substance Use Disorders ☐ Fixed Charges

☐ Pharmacy ☐ Dental ☐ Vision

☐ Other: _____

PRODUCT FEATURES FOR AGGREGATE STOP LOSS COVERAGE:

☐ Annual Reconciliation

☐ Other: _____

EXPECTED MONTHLY ATTACHMENT FACTOR BY PRODUCT

Product/Benefit Option	Factor	Product/Benefit Option	Factor
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$

MINIMUM ATTACHMENT POINT: (Applies to Annual Reconciliation only): $_____

MINIMUM ATTACHMENT PERCENTAGE: ___%

MAXIMUM REIMBURSEMENT LIABILITY FOR AGGREGATE STOP LOSS: will be $___ for the Policy Year BENEFIT PERCENTAGE PAYABLE: _____%

BENEFIT ELIGIBILITY BASIS:

Initial Policy Period: _____ to _____

Unless additional options are selected below, claims must be both Incurred and paid during the policy period.

☐ Paid in 12 months (available only for previously Cigna administered customers)

Run-In Provision: Claims Incurred prior to the policy's Effective Date and paid during the policy period.

☐ N/A ☐ _____ months

☐ Run-In claims are limited to: $_____

Run-Out Provision: Claims Incurred during the policy period and paid after termination of the policy.

☐ N/A ☐ _____ months

☐ OTHER REQUESTED PROVISIONS: _____

ESTIMATED MONTHLY AGGREGATE PREMIUM RATES: $___*

* Actual Rates will be contained in the Stop Loss Policy, if and when issued.

COMMENTS

8. The Applicant agrees that:

   a. The Applicant has read the entire Application and certifies that the underwriting information presented to Cigna, whether provided by the Applicant or any person acting on behalf of or at the direction of the Applicant, voluntarily or in response to Cigna's request, is complete and accurate. Such underwriting information, if any, is considered to be part of this Application.

   b. Any policy issued based on this Application, together with any of its Schedule of Insurance, amendments or riders, shall control the stop loss insurance coverage and terms and conditions of such insurance. In the event of a conflict between the Application and terms of the Policy, the Policy shall prevail.

   c. No person, other than a duly authorized officer of Cigna or its delegate has authority to accept and approve this Application, or otherwise alter any policy provisions or waive any of Cigna's rights or requirements.

FRAUD WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

All application statements, in the absence of fraud, made by the Applicant shall be deemed to be representations, not warranties.

DATED AT_____ THIS_____ DAY OF_____ 20_____

APPLICANT **Pinellas County Board of Commissioners**

BY_____ TITLE_____
(Applicant's designated individual's signature)

LICENSED AGENT NAME:_____

AGENT SIGNATURE:_____ FLORIDA LICENSE NUMBER:_____

ONCE COMPLETED AND SIGNED, MAIL TO THE STOP LOSS CONTRACTING UNIT.

Mailing Address:
Cigna Health and Life Insurance
Company Attn: Stop Loss Unit - B2STL
900 Cottage Grove Rd.
Hartford, CT 0615

Attachment 7 – Stoploss Policy

Stop Loss Policy to be provided by Cigna once the signed Stoploss application is received.

Attachment 8 - 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 this Agreement.