EXHIBIT D
Modifications to Administrative Services Only Agreement

Aimee E. Burnham
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Cigna Healthcare

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June 20, 2024

Emily Cooper
Benefits Manager
County of Boulder, State of Colorado
2020 13th Street
Boulder, CO 80302

RE: Administrative Services Only Account No. 3328645

Dear Emily Cooper:

This letter will serve as an amendment to the Administrative Services Only Agreement between Cigna Health and Life Insurance Company ("**Contractor**") and County of Boulder, State of Colorado ("**County**"), effective January 1, 2021, (the "**Agreement**") and as amended on January 1, 2022, and January 1, 2023.

Effective as of January 1, 2024, the Agreement is hereby amended as set forth below. Any provision or subsection set forth in this amendment shall be deemed to: (a) replace in its entirety the same subsection in the current Agreement; and/or (b) add new provisions or subsections. Only those provisions and subsections set forth in this amendment are deemed amended or added, and all provisions and subsections not identified herein shall be deemed unaffected by this amendment and, accordingly, shall remain in full force and effect.

Section 1.iv of the Administrative Services Only Agreement, is hereby amended in its entirety as follows:

iv. The date upon which County fails to pay Contractor any charges identified in this Agreement when due provided Contractor notifies County of its election to terminate; or

Section 2.d of the Administrative Services Only Agreement is hereby amended in its entirety as follows:

d. In addition to the basic claim administrative duties described above, Contractor shall also perform the Plan-related administrative duties agreed upon by the Parties and specified in Exhibit D. Unless otherwise agreed to in writing by Contractor, all services identified in this Agreement shall be provided by Contractor to County and to Members covered by this Agreement on an exclusive basis with respect to that portion of the Plan administered by Contractor pursuant to this Agreement.

Section 3.a of the Administrative Services Only Agreement is hereby amended in its entirety as follows:

a. County shall establish a Bank Account, and maintain in the Bank Account an amount sufficient at all times to fund payments from it for the following (collectively "**Bank Account Payments**"): (i) Plan Benefits; (ii) those charges and fees identified in the applicable Schedule of Financial Charges as payable through the Bank Account and (iii) any sales tax, or similar benefit- or Plan-related charge, surcharge or assessment however denominated, which may be imposed by any governmental authority. Bank Account Payments may include without limitation: (a) fixed per person payments and pay-for-performance payments to Participating Providers; (b) amounts owed to Contractor which are not billed to County in accordance with Section 4 of this Agreement; and (c) amounts paid to Contractor's affiliates and/or sub Contractors 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.

Section 3.d of the Administrative Services Only Agreement is hereby amended in its entirety as follows:

d. Contractor will promptly adjust any underpayment of Plan Benefits or pay-for-performance payments by drawing additional funds due the claimant from the Bank Account. In the event Contractor determines that it has overpaid a claim for Plan Benefits or paid Plan Benefits to the wrong party, it shall take all reasonable steps consistent with the policies and procedures applicable to its own health care insurance business to recover the overpayments of Plan Benefits. Contractor shall also take all reasonable steps consistent with the policies and procedures applicable to its own health care insurance business to collect pay-for-performance payments due to County or to recover pay-for- performance overpayments (collectively "Pay-for-Performance Recoveries"). 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 indirect, associated third party costs absent consent of Contractor. Contractor shall not be responsible for reimbursing any unrecovered payments of Plan Benefits or Pay-for-Performance Recoveries unless made as a result of its gross negligence or intentional wrongdoing.

Section 3.e of the Administrative Services Only Agreement is hereby amended in its entirety as follows:

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

Section 4, "Charges," of the Administrative Services Only Agreement is hereby amended in its entirety as follows:

Section 4. Charges

a. Charges. Contractor shall provide to County a monthly statement of all charges County is obligated to pay, in full, under this Agreement that are not paid as Bank Account Payments. Payment of all billed charges shall be due on the first day of the month, as indicated on the monthly statement. Payments received after the last day of the month in which they are due, shall be subject to late payment charges, from the due date at a rate calculated as follows: the one (1) year Treasury constant maturities rate for the first week ending in January plus five percent (5%). For purposes of calculating late payment charges, payments received will be applied first to the oldest outstanding amount due. Contractor may reasonably revise the methodology for calculating late payment charges upon thirty (30) days' advance written notice to County.

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 payment of all applicable charges and Bank Account Payments incurred or charged through the date Contractor processed County's notice of a retroactive change or termination of a Member. 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.

The obligations set forth in this Section 4 shall survive termination of this Agreement.

Section 5.a of the Administrative Services Only Agreement is hereby amended in its entirety as follows:

a. Eligibility Determinations and Information. County is responsible for administering Plan enrollment. In determining any person's right to benefits under the Plan, Contractor shall rely upon enrollment and eligibility information provided by the County and Contractor shall have no liability for administering the Plan in reliance upon enrollment and eligibility information provided by County. Such eligibility information shall identify the effective date of eligibility and the termination date of eligibility and shall be provided promptly to Contractor on at least a monthly basis (unless otherwise agreed to in writing by Contractor) using a method and with such other information as reasonably may be required by Contractor for the proper administration of the Plan.

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

Section 6. Audit Rights

a. County may audit Contractor's administration of Plan Benefits at no additional charge while this Agreement is in effect and in accordance with the following requirements:

i. Notification and timing of audit.

a. For a clinical audit, County shall provide to Contractor a scope of audit letter, which scope shall be mutually agreed upon by the parties, and a fully executed audit agreement, together with a ninety (90) day advance written request to audit.

b. For all other audits described below, County shall provide to Contractor a scope of audit letter, and a fully executed audit agreement, 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 audit agreements which shall be signed by the Auditor prior to the start of the audit.

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

vi. County shall be responsible for its Auditor's costs. In the event County requests to alter the scope of the 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.

vii. If County has five thousand (5,000) or more employees who are Members, County may conduct one such audit every Plan Year (but not within six (6) months of a prior audit); otherwise, County may conduct one such audit every two (2) Plan Years (but not within eighteen (18) months of a prior audit).

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

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

x. County may (as determined by Contractor based upon the resources required by the audit requested) be responsible for Contractor's reasonable costs with respect to the audit, except that while this Agreement is in effect there shall be no additional cost to County for an audit of the following:

- **Claims:** Payment documents relating to a random, statistically valid sample of two-hundred twenty-five (225) claims paid.
  - Requests to review provider contracts will be subject to Contractor's current criteria and and contrary terms in Participating Provider Agreements.
- **Appeals:** Documents, including payment documents as appropriate, relating to a random sample of up to thirty-five (35) appeals.
- **Customer Service:** Documentation and review of call recordings relating to a random sample of up to thirty-five (35) Member calls.
  - Contractor 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. CONTRACTOR will support the benefit implementation audits for review of benefit set up related to claim processing.
- **Medical Cost Containment Program Fees (MCCP) (Out-of-Network Protection and Payment Integrity Program Fees):** MCCP audits are limited to confirmation of fees paid by the County related to the programs in place. The audits will not include review of documentation that is not applicable to claim administration. In addition, Auditor will need to agree 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 based on the following:
  - Twenty-five (25) claims in which fees were paid for Medical Out-of-Network Protection Programs which include Network Savings Program and Bill Negotiation Services (Pre-payment Cost Containment for Non-contracted claims)
  - One-hundred (100) claims in which fees were paid related to Payment Integrity Programs which include Medical Bill Review; Medical Implant Device Review; Clinical Waste and Abuse Claim Review; High-Cost Specialty Pharmaceutical Review; other target billing accuracy review programs; Diagnosis Related Grouping Review; Coordination of Benefits (COB) Investigation and Recoveries; Secondary Vendor Recovery Program; Provider Credit Balance Recovery Program; Eligibility Overpayment Recovery Vendor Services; and Subrogation/Conditional Claim Payment.

- **Clinical Cases/Calls**: The standard annual allowable number of cases/calls for audit and standard number of days allowed to conduct the audit is as follows, based on number of County Subscribers during the time period covered by the audit:

Number of Subscribers	# Cases	# Calls	# Days*
5,000 & under	10	3	1
>5,000 & < 25,000	15	4	1
>25,000 & < 75,000	20	5	1.5
>75,000	25	6	2

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

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

Section 7.a of the Administrative Services Only Agreement is hereby amended in its entirety as follows:

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. County is responsible for reimbursing Contractor, its directors, officers and employees for any reasonable expense incurred (including reasonable attorneys' fees) by them in the defense of any action or proceeding involving a claim for Plan Benefits except to the extent such claim arises from Contractor's gross negligence, willful misconduct or a material breach of this Agreement. Contractor shall reasonably cooperate with County, in its defense of such actions.

If County 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. County

shall reimburse Contractor for any liability or expenses (including reasonable attorneys' fees) Contractor may incur in connection with or in defense of its making such payments.

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

Exhibit E, "Audit Agreement (Sample)," of the Administrative Services Only Agreement is hereby deleted in its entirety and left intentionally blank.

Exhibit E1, "Clinical Audit Agreement (Sample)," of the Administrative Services Only Agreement is hereby deleted in its entirety.

The terms of the Administrative Services Only Agreement identified above, as mentioned herein, will be effective as of January 1, 2024. Please indicate your agreement to the amendment by signing the enclosed copy of this letter where indicated and returning it to me. Alternatively, this amendment shall become effective on the effective date indicated unless County notifies Contractor either electronically or in writing (at the address indicated above) within sixty (60) days of the date of this letter that it does not accept all the terms of this amendment notwithstanding any provision to the contrary in the Administrative Services Only Agreement. In that case, Contractor shall cooperate to negotiate mutually agreeable terms with County. Once agreement with respect to the terms of the amendment is reached, the amendment will apply retroactively to the effective date.

Sincerely,

Printed Name: Aimee E. Burnham

Title: Its Contractual Agreement Unit Manager

Duly Authorized

Cigna Health and Life Insurance Company

Accepted by: **COUNTY OF BOULDER, STATE OF COLORADO**

By: _____

Printed Name: _____

Title: Its _____

Executed this ____ day of _____, in the year _____

Exhibit B- Schedule of Financial Charges

Certain fees and charges identified in this Schedule of Financial Charges will be billed to County monthly in accordance with Contractor's then standard billing practices. However, Contractor 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	**$40.59/employee/month**
Medical	HSA Open Access Plus (OAP) with Care Management Preferred (OAP- Non Cobra HSA)	**$43.59/employee/month**
Medical	HSA Open Access Plus (OAP) with Care Management Preferred (OAP- Cobra HSA)	**$40.59/employee/month**
Medical	HSA LocalPlus (LCP) with Care Management Preferred (Local Plus- Cobra HSA)	**$40.59/employee/month**
Medical	HSA LocalPlus (LCP) with Care Management Preferred (Local Plus- Non Cobra HSA)	**$43.59/employee/month**
Medical	LocalPlus (LCP) with Care Management Preferred	**$40.59/employee/month**
	MEDICAL NETWORK ACCESS FEE, UTILIZATION MANAGEMENT FEE AND OPTIONAL PROGRAM FEE	
Product	**Description**	**Charge**
Medical	OAP Access Fee	**$23.51/employee/month Included in Medical Administration Charge**
Medical	HSA OAP Access Fee (All Plans)	**$23.51/employee/month Included in Medical Administration Charge**
Medical	HSA LCP Access Fee (All Plans)	**$23.51/employee/month Included in Medical Administration Charge**

Medical	LCP Access Fee	**$23.51/employee/month Included in Medical Administration Charge**
MULTI-YEAR CHARGE/FEE GUARANTEES		
	The maximum increase for the Medical Administration Charge(s) and Network Access Fee(s) for the 2025 Plan Year will be 2.00% over the 2024 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 Contractor may revise the above charges/fees pursuant to Section 8.a.ii, 8.a.iii and/or 8.a.iv of this Agreement.	
	CIGNA CHOICE FUND AND OTHER CONSUMER DIRECTED ACCOUNT ADMINISTRATION SERVICES AND CHARGES	
	Product	**Charge**
	Cigna Choice Fund Health Savings Account (HSA) Administration (Non-Cobra Only)	**For HSA OAP (OAP- Non Cobra HSA)** **and HSA LCP (Local Plus- Non Cobra HSA) Products: $3.00/employee/month Included in Medical Administration Charge**
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.	**For HSA OAP** **and HSA LCP Only: Included in Medical Access Fee**

	• 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.	

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

CIGNA HOME DELIVERY PHARMACY DISCLOSURE		
	Product	**Charge**
Cigna Home Delivery Pharmacy (a Contractor 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 Contractor 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 Contractor offers	**The drug's charge under a national specialty drug discount schedule that generates a 19.00% annual average aggregate discount off AWP across specialty drug claims dispensed at Cigna Home Delivery Pharmacy to Contractor's self-funded**

	to entities like County that sponsor group health plans. Discounts and fee-for-service payments received by Cigna Home Delivery Pharmacy are not part of the administrative fees or other charges paid to Contractor in connection with Contractor 's services hereunder. This provision shall survive termination or expiration of the Agreement.	**and insured group-client book of business.**
FEES FOR PROCESSING RUN-OUT CLAIMS		
OAP, HSA OAP, HSA LCP and LCP	Run-Out Period of twelve (12) months Contractor shall not be required to process Run-Out Claims until it has received full payment of the required fees.	**The sum of the last four (4) months of billed fees applicable to the terminated (i) Agreement, (ii) Plan benefit option or (iii) Member eligibility.**

CHLIC MEDICAL OUT-OF-NETWORK PROTECTION PROGRAM FEES

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

Contractor's charges for administering the OON Protection Programs ("OON Protection Program Charges") are set forth in the tables below and are calculated for each claim based on the applicable percentage of the:

1) "Gross Savings" (i.e., the difference between the charge the provider made or would have made, and the allowable amount resulting from the OON Protection Programs); or

2) "Net Savings" (i.e., the Gross Savings less the applicable Vendor Charge).

OON Protection Program Charges, plus any per claim Vendor Charge, shall not exceed $30,000 per claim (the "Per Claim Cap"). Vendor Charges generally range from 5-11% of Gross Savings but may change from time to time.

Contractor will make a per claim charge to the Bank Account that includes both Contractor's applicable OON Protection Program Charges, as shown in the tables below, and the applicable Vendor Charge. Contractor will pay the vendor its charge. OON Protection Program Charges will appear in County's Bank Account activity data reports.

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

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

OON Protection Programs seek to reduce providers' charges to amounts that Cigna, in its discretion, determines are market competitive ("Discounts"). Cigna, or a vendor retained by Cigna, may attempt to obtain Discounts through accessing a provider's agreement with a third party or negotiating the provider's charges. Negotiations may include (i) Cigna, or a vendor retained by Cigna, entering into an agreement with the provider that establishes the amount at which the provider is willing to accept as payment in full; or (ii) using repricing programs through which Cigna, or a vendor retained by Cigna, determines the allowed amount based on a rate deemed to be market competitive and the provider does not bill the patient and/or obligate the patient to pay the difference between the charged amount and the allowed amount.

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

Discounts may be determined on a claim-by-claim basis before or after services are rendered.

If no Discount is applied through OON Protection Programs, reimbursement will be based on the terms of the benefit Plan.

1.	Network Savings Program	**29% of net savings**
2.	Bill Negotiation Services Programs (Inpatient, outpatient, physician/professional)	
	• Supplemental Network	**29% of net savings**
	• Professional Fee Negotiation	**29% of net savings**
	• Line-Item Analysis Re-pricing (outpatient, physician/professional)	**29% of net savings**

	• Line-Item Analysis Re-pricing (inpatient hospital)	**Gross savings up to 5% of the hospital bill**
3.	Negotiation or independent dispute resolution under state laws, if applicable, addressing reimbursement to Non-Participating Providers, where payment is not based on the Network Savings Program or Bill Negotiation Services Programs. If additional payment is owed as a result of negotiations or independent dispute resolution under state law, Contractor, as agent for the County, shall make Bank Account Payments from the Bank Account in the amount of such additional payment. (There are no additional fees charged to the County for handling the independent dispute resolution process.)	**29% of net savings**
B. OON Protection Programs for NSA Services For NSA Services, Contractor will issue initial payments at amounts determined by Contractor or its vendors ("Initial Allowed Amount"). The Initial Allowed Amount may be based on Discounts and may be higher than, equal to, or lower than the recognized amount or qualifying payment amount (QPA), as calculated by Contractor. Patient cost-share will be based on the lower of the QPA, the non-Participating Provider's billed charges, the amount determined by Contractor to be required by state law (if applicable), or the Initial Allowed Amount. Patient cost-share will not increase as a result of negotiations or independent dispute resolution determinations under the No Surprises Act. If additional payment above the Initial Allowed Amount is owed as a result of negotiations or independent dispute resolution under the No Surprises Act, Contractor, as agent for the County, shall make Bank Account Payments from the Bank Account in the amount of such additional payment.		
1.	Network Savings Program	**29% of net savings**
2.	Bill Negotiation Services Programs (Inpatient, outpatient, physician/professional)	
	• Supplemental Network	**29% of net savings**
	• Professional Fee Negotiation	**29% of net savings**
	• Line-Item Analysis Re-pricing (outpatient, physician/professional)	**29% of net savings**
	• Line-Item Analysis Re-pricing (inpatient hospital)	**Gross savings up to 5% of the hospital bill**
3.	Negotiation or independent dispute resolution under the federal No Surprises Act, where payment is not based on the Network Savings Program or Bill Negotiation Services Programs.	**29% of net savings**

	If additional payment is owed as a result of negotiations or independent dispute resolution, Contractor, as agent for the County, shall make Bank Account Payments from the Bank Account in the amount of such additional payment. (There are no additional fees charged to the County for handling the independent dispute resolution.)	

CONTRACTOR MEDICAL PAYMENT INTEGRITY PROGRAM FEES

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

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

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

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

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

1.	Bill Review, Clinical coding validation and editing (Pre- and Post-payment) Includes: • Hospital Bill Review (Inpatient/Outpatient) • Medical Implant Device Review (Inpatient/Outpatient) • Clinical Waste and Abuse Claim Review (Facility & Professional) • High-Cost Specialty Pharmaceutical Review • Other Target Billing Accuracy Programs	**If there is savings or recovery, any fees or expenses passed through by the hospital or regulatory agency, plus 29% of the gross savings/gross recovery**
2.	Diagnosis Related Grouping (DRG) Review (Pre- and Post-payment) to ensure coding is consistent with care rendered and coding standards.	**If there is savings or recovery, any fees or expenses passed through by the hospital or**

		regulatory agency, plus 29% of the gross savings/gross recovery
3.	Coordination of Benefits (COB) Investigation and Recoveries to identify if Member has other insurance. Includes Medicare and other commercial health coverage.	**29% of the gross recovery**
4.	Secondary Vendor Recovery Program. Specialized vendor partners run proprietary queries to determine the reasonableness, appropriateness, accuracy, and applicability of select claim payments	**29% of the gross recovery**
5.	Provider Credit Balance Recovery Program. Audit/reconciliation of facility accounts which are in a negative balance, due to incorrect billing or payment made to a provider.	**29% of the gross recovery**
6.	Eligibility Overpayment Recovery Vendor Services. Identification and recovery of funds in situations where the overpayment is due to the late receipt of Member termination information.	**29% of the gross recovery**
7.	Subrogation/Conditional Claim Payment. Identification, investigation, and recovery of claim payments involving other party liability or where another entity is responsible for payment (including by way of example but not by limitation automobile insurance, homeowner insurance, commercial property insurance, worker's compensation).	**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.** **Litigation costs if counsel is retained and an appearance is filed on behalf of**

		Contractor **or County in any litigation, or a lawsuit is filed on their behalf, plus 5% of the gross recovery.**
8.	Medical Cost Class Action Recoveries. Contractor identifies, monitors, and may (but is not required to) participate, on behalf of County, as a plaintiff in class action lawsuits or similar legal proceedings against third parties whose actions entitle County to recover damages for medical costs it paid as Plan Benefits (e.g. medical device product liability class actions, mass tort recovery class actions, etc.), including, without limitation, lawsuits alleging legal or equitable claims like product liability, fraud, anti-trust violations, or unfair trade practices. As part of this authority, Contractor may participate in a settlement, exclude County from a settlement and/or otherwise represent County's interests outside the settlement. Contractor collects and retains a percentage any recovery (net of attorneys' fees) attributable to County's Plan as compensation for these services.	**35% of the gross recovery**
CIGNA PATHWELL SPECIALTY SM		
Cigna Pathwell Specialty	Cigna Pathwell Specialty℠ is a network benefit that manages certain injected and infused specialty medication costs by guiding Members to cost-effective and clinically appropriate in-network Pathwell Specialty Providers[1], including specialty pharmacies (which may include Contractor affiliates) and other treatment settings. It is supported by a high-touch Cigna Pathwell Specialty Care Management Team, which proactively guides Members using out-of-network providers to in-network benefits while also providing Members with education and referrals to other Cigna health programs, including those focused on wellness and behavioral health as appropriate. Additionally, both Members and providers have access to easy-to-use provider look-up tools with geolocation features that identify in-network Pathwell Specialty Providers. [1] "Pathwell Specialty Providers" means an in-network specialty pharmacy the health care professional orders medication from or the place (location) where Participants are having their treatment done.	**All Medical Products Except Cigna SureFit, Comprehensive, Indemnity, Network, Network OA, Network POS, and Network POSOA**

Except as provided below, for in-network medical claims covered under the Pathwell Specialty benefit, County shall pay Contractor according to the following Average Sales Price (ASP) schedule whereby the category equates to the type of Pathwell Specialty Provider. ASP is used to the extent available. If ASP is not available, Contractor may use a reasonable substitute. Contractor follows a rational, reasonable, and auditable process to establish categories and ASP ranges by category. Subject to execution of a mutually agreed upon audit agreement, third party audits of the process used to categorize a type of provider or the assignment of ASP % on a select set of claims can be arranged upon County request. Pathwell Specialty Providers will be assigned to a tier based on their contracted rates. Pathwell Specialty Providers will not be moved between tiers mid-calendar year unless there is a change in their contracted Pathwell Specialty rates or a market event. Review of provider tiers outside of changes to the contracted rates will occur on an annual basis. The distribution and list of providers across tiers within the Cigna Pathwell Specialty℠ network, will be provided upon County request.

Category	**ASP Range**
Tier A: Office, Home, Free Standing Infusion Suites, and Specialty Pharmacies	106% - 135% ASP
Tier B: Office, Home, Free Standing Infusion Suites, and Specialty Pharmacies	136% - 160% ASP
Tier C: Office, Home, Free Standing Infusion Suites, and Specialty Pharmacies	161% - 190% ASP
Tier D: Outpatient Hospital	120% - 155% ASP
Tier E: Outpatient Hospital	156% - 190% ASP
Tier F: Outpatient Hospital	191% - 225% ASP
Tier G: Outpatient Hospital	226% - 260% ASP

County understands and agrees that the amount paid by Contractor to the Pathwell Specialty Provider for such claims may or may not be equal to the amount charged to County and Contractor will absorb or retain any difference. Additional reporting available upon request.

In some instances, the in-network charge for specialty medications from Pathwell Specialty Providers will be based upon their provider contract and not in accordance with the above ASP Schedule. In the event of contract or market changes, these Pathwell Specialty Providers may be added during a calendar year to a tier under the ASP Schedule and reimbursement would

	then be based upon the ASP Schedule. Similarly, a Pathwell Specialty Provider who began the calendar year in a tier under the ASP Schedule may be moved to charges for specialty medications based upon their provider contracts rather than the ASP Schedule in the event of a contract or market change. To the extent a claim is submitted by a Pathwell Specialty Provider such that a data error is indicated, the claim would not be subject to the ASP schedule, above.	
EMBARC BENEFIT PROTECTION® A NETWORK SOLUTION FOR CERTAIN HIGH-COST GENE THERAPY DRUGS		
Embarc Benefit Protection	To provide financial protection from the high cost of certain gene therapy drugs, Contractor has contracted with an affiliate, eviCore ("eviCore" refers to eviCore healthcare MSI, LLC d/b/a/ eviCore healthcare and certain of its affiliates), to arrange for the provision of the gene therapy drugs listed on Cigna.com and Evernorth.com for Members when the indicated drugs are covered by the Plan administered by Contractor, and medically necessary (as determined by Contractor). Gene therapy drugs are continually being evaluated and may be added to the network solution after FDA approval. The complete list of included drugs and any associated contractual limitations can be found at both Cigna.com and Evernorth.com. 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 Contractor on a fixed Per Member Per Month (PMPM) basis. eviCore's PMPM fee (which is subject to change) will be charged to the Bank Account one month in arrears. (e.g., eviCore's charges for January will be made in February.) These Bank Account Payments will appear in County's monthly reporting. Embarc Benefit Protection does not provide financial protection from the cost of administering these drugs. These costs are small in comparison to the drug costs.	**$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 covered drugs provided in a given calendar year is lower than a predetermined percentage of the PMPM charges received, eviCore will refund the difference pro rata, for both active and terminated clients, after having fully recovered the outstanding balance created by any prior year deficits. The

	When covered under the Plan and determined by Contractor to be medically necessary for the treatment of the specified conditions, Members will not incur any out-of-pocket costs for the drugs and the Plan will not be required to reimburse any expenses for the drugs with the following exceptions: Exceptions: 1. Members with an HSA must have met the applicable minimum deductible required for a high deductible health plan. 2. As otherwise stated on Cigna.com or Evernorth.com **eviCore's Embarc Benefit Protection and PMPM charge do not apply to a plan that:** i. does not cover all drugs included in Embarc Benefit Protection; ii. covers any of the drugs exclusively under its pharmacy benefits which are not administered by Contractor, or iii. does not utilize an eviCore participating provider. Upon County's request on or after the Effective Date, Contractor shall provide to County an updated drug list, if applicable. Contractor may revise charges/fees by giving County at least thirty (30) days' prior written notice.	refund, if any, will be determined on an eviCore Embarc benefit Protection book-of-business basis. The refund will be provided by March 31st of the following year. Assuring Transparency: After the refund is made for a particular calendar year, eviCore will, upon request, provide Embarc Benefit Protection book-of-business information for that calendar year.
ADVANCED CELLULAR THERAPY PROGRAM		
Advanced Cellular Therapy Program	The Advanced Cellular Therapy Program (ACT) is an enhanced network benefit solution designed to manage the high cost of advanced cellular therapies (e.g. CAR T-cell therapy). This program delivers predictability, clinically appropriate care and maximizes affordability by leveraging a specially selected provider network, with benefit language that includes a travel benefit and a dedicated care management team to support Participating Members receiving these therapies.	

	For all in-network medical claims covered under the ACT Program at an existing ACT participating provider, County shall pay Contractor (who in turn will pay the rendering ACT participating provider) a Guaranteed Price for the covered advanced cellular therapy. The Guaranteed Price shall equal the Average Wholesale Price (AWP) of the covered advanced cellular therapy minus 10% and will be charged to the Bank Account. Guaranteed Price for the covered advanced cellular therapy (ACT) | AWP minus 10% *For purposes of the ACT Program, "Average Wholesale Price" or "AWP" shall mean the average wholesale price of a covered drug as established and reported by Medi-Span. The applied AWP of a covered drug shall be the AWP for the actual eleven (11) digit National Drug Code ("NDC"), at the time that the covered drug is adjudicated. Notwithstanding any other provision in this Agreement, in the event of any major change in market conditions affecting the pharmaceutical or pharmacy benefit management market or if* Contractor *decides to replace AWP as its pricing benchmark with an alternative benchmark and/or replace Medi-Span, or other such publication, as its source for the AWP, or alternative benchmark with a different pricing source,* Contractor *may adjust the Guaranteed Price as it reasonably deems necessary to preserve the economic value or benefit of the Guaranteed Price to* Contractor *as it existed immediately prior to such change.* County understands and agrees that the amount paid by Contractor for the therapy may or may not be equal to the Guaranteed Price charged to County and Contractor will absorb or retain any difference. There are related costs for Participating Members receiving these therapies that will be paid as covered services according to the Plan.	
CARE MANAGEMENT/COST CONTAINMENT PROGRAM FEES		
	Contractor 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 Contractor, and/or (ii) improve adherence to evidence-based guidelines designed to promote patient safety and efficient patient care.	**Applicable third-party fees and care management program services are listed below, and additional details are**

	Unless otherwise specified in this Schedule of Financial Charges, charges for these services will be processed through the Bank Account.	**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, Contractor has arranged for an affiliate, eviCore, to provide the following care management/cost-containment programs:	
	Pre-certification of coverage of radiation therapy services.	**$958.00 per episode of care (EOC)**
	Pre-certification of coverage of diagnostic cardiology services.	**$0.19 PMPM**
	Pre-certification of coverage of medical oncology services.	**$1,103.00 per episode of care (EOC)**
	Oncology Consult Service. Medical oncology cases submitted for prior authorization will be subject to additional review against certain clinical criteria, including the appropriate setting of care/service, to determine if the case would benefit from a physician-to-physician consult focused on the accuracy of the diagnosis and the optimal treatment plan. eviCore will engage a third party to facilitate the consultation, which will occur only upon acceptance by physician and the consent of the Participant.	**$3,800.00 per completed consultation** **(Billed directly to County)**
	Pre-certification of coverage of musculoskeletal therapy services.	**$0.41 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	**Fee reimbursement method and rates may vary by market and are available upon request**.

	based on eviCore's contracted rate with that provider. In such instances, Plan Benefits and member cost-share will be determined based on the rate that eviCore contracted to pay the provider for the provision of the service or supply. eviCore may also charge for services related to the provision of high-tech radiology as described below in "Other Vendors and Health Care Services Providers."	
	Pre-certification of coverage of gastroenterology services.	**$0.11 PMPM**
	Pre-certification of coverage for appropriate setting of care/service for high-tech radiology services	**$0.17 PMPM**
	Pre-certification of coverage for appropriate setting of care/service for certain medical oncology drugs (redirection may be to Accredo, a Contractor 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:** Contractor **may retain a portion of the shared savings fee before**

		reimbursing eviCore.
	Pre-certification of coverage of sleep management services.	**$0.12 PMPM**
	Network management and care coordination of coverage of home health, durable medical equipment and home infusion services.	**$0.32 PMPM**
	CONTRACTOR may revise charges/fees by giving County at least sixty (60) days' prior written notice.	
EXTERNAL REVIEW AND CONSULTATIVE REVIEW FEES		
	When a Member elects an External Review (as that term is defined in the Patient Protection and Affordable Care Act (PPACA)) of a benefit determination by an independent third party, the cost of a specific third party review is dependent on the nature and complexity of the issue on appeal. Third party review charges will be commensurate with the level of expertise necessary and the time required to complete the review.	**$500-$1,500 Per Review**
STRATEGIC ALLIANCES		
	CONTRACTOR contracts directly or indirectly with other managed care entities and third party network vendors for access to their provider networks and discounts. These third parties charge a network access fee, which is included in Contractor 's monthly charges, as a result of the application of their discounts. Additional details regarding specific charges will be provided upon request.	**All Medical Products**
OTHER VENDORS AND HEALTH CARE SERVICES PROVIDERS		
	The fixed per person per period and/or fee-for-service charges that Contractor has directly or indirectly negotiated with Participating Providers for in-network health care services and/or supplies will be charged to the Bank Account and will be used in calculating any applicable Member cost-sharing. In addition, performance-based payments to Participating Providers will be charged to the Bank Account. Such payments will be at the payment rates then in effect, which may be amended from time to time. For certain types of specialty care, including, but not limited to, home health care, durable medical equipment, sleep management, high tech radiology, chiropractic care, acupuncture, physical medicine (such as physical and occupational therapy), speech therapy, orthotics and prosthetics, implants, and hearing, in certain markets Contractor may contract with various	**All Products**

	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 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. Contractor'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 Contractor affiliates, and the form of payment that they currently receive.	

	NOTICE REGARDING PAYMENTS FROM THIRD PARTIES	
Rebate and Other Remuneration Disclosure (Medical)	Contractor may directly or indirectly receive and retain payments under contracts with pharmaceutical manufacturers or third parties with respect to Members' utilization of the manufacturer's products covered under the County's Plan medical benefit. These payments may include rebates, service fees (e.g. administrative fees), or other remuneration. Contractor directly or indirectly contracts with pharmaceutical manufacturers or other third parties for any remuneration on its own behalf, based on its book of business, and for its own benefit, and not on behalf of County or the Plan. Accordingly, Contractor retains all right, title and interest to any and all such remuneration received from manufacturer; neither County, its Members, nor County's Plan retains any beneficial or proprietary interest in any such remuneration, which shall be considered part of the general assets of Contractor. This provision shall survive termination or expiration of the Agreement.	**All Medical Products**
Implementation/Referral Fee Disclosure	From time to time, Contractor, 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. Contractor and its affiliates may receive payments from such third parties to help defray Contractor '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 Contractor. Contractor may also receive compensation from third-party vendors that County may retain based upon a referral from Contractor or that Members may utilize following an introduction facilitated by Contractor or an affiliate. Contractor may also receive: • network administration fees from some providers participating in its provider network,	**All Products**

	• 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.	
COMPLIANCE ASSISTANCE		
	Contractor shall provide the following services to assist County in meeting its compliance obligations under section 2715 of the Public Health Service Act as added by the Patient Protection and Affordable Care Act and applicable regulations with respect to the provision of the Summary of Benefits and Coverage ("**SBC**"), translation notice and glossary. Applicable to all medical plans including HRA and FSA which are considered "group health plans" subject to the SBC requirements.	
1.	Preparation of SBC, translation notice. Contractor will not be responsible for any changes that County makes to the SBC.	**No charge**
2.	Provide SBC, translation notices prepared by Contractor to County electronically as well as any updates or material modifications.	**No charge**
3.	Include in SBC a summary of benefits administered by carve-out vendor if County or carve-out vendor provides Contractor with necessary carve-out benefit information at least twelve (12) weeks prior to the date the SBCs are to be delivered to County.	**$500 for each benefit option under the Plan for which carve-out vendor benefits are included in SBC**
ADDITIONAL SERVICES		
Service	**Description**	**Charge**
Behavioral Health	Access to inpatient behavioral health services and focused utilization review and case management for inpatient, in-network behavioral health services. When applicable, only to Members in CA/VI.	**For OAP,** **HSA OAP,** **LCP** **and HSA LCP Products:**

		Included in Medical Access Fee
Comprehensive Maternity Program	Cigna Healthy Pregnancies, Healthy Babies™ program is a comprehensive maternity management program. The goal of the program is to reduce the number of pre-term and underweight babies by promoting a healthy pregnancy. Expectant mothers can enroll using either the Cigna Pregnancy App (no additional cost for both Apple and Android platforms), or call to speak with a HPHB team member over the phone. The program delivers education and telephonic support to pregnant women through the post-partum period. Nurses answer medical related questions and make suggestions for behavior changes and medical interventions aimed at improving the health of the mother and baby. Program support also covers preconception and infertility. Financial incentives may be awarded to women at the completion of this self-referral program based on the trimester enrolled. Incentives Elected:	
	Option 3 (Low): $150 – 1st Trimester/$ 75 – 2nd Trimester	**For OAP,** **HSA OAP,** **LCP** **and HSA LCP 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 OAP,** **HSA OAP,** **LCP** **and HSA LCP Products:**

		Included in Medical Access Fee
Clinical Program	A targeted condition medication therapy management program in which Contractor provides support for Members using specialty medications for certain chronic conditions and that are obtained or administered at retail pharmacies or outpatient, office or home health care settings. As part of the program, Members are assisted with any questions they may have around medication side effects, given explanation around their Plan benefits, informed of the importance of adherence, assist with the prior authorization renewal coordination, assist with referrals to Contractor Integrated Pharmacy Solutions clinicians and referrals to other Cigna coaching programs. Contractor acts as the primary point of contact for Members enrolled in specialty condition counseling and works to ensure that Member needs are coordinated and referred appropriately. Contractor conducts standardized assessments of Members to identify potential clinical issues and works in conjunction with nurses, pharmacists, and other parties to resolve. For the sake of clarity, if a specialty pharmacy affiliate of Contractor 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 Contractor; Contractor does not exert direction or control over the pharmacists at any specialty pharmacy affiliate.	**For OAP,** **HSA OAP,** **LCP** **and HSA LCP Products: Included at No Additional Cost**
Your Health First	A proactive health education and improvement program for Members with a chronic condition. The program involves services that span across the Member's health needs. Behavioral coaching principles and evidence-based medicine guidelines are utilized to optimize self-management skills and foster sustained health improvements. The program targets a chronic population at high risk for near term and future high-cost medical expenses. Members are identified as having a chronic condition through a variety of sources which may include: claims data, referrals, and self-identification. A variety of resources is provided to those with a chronic condition, including access to online tools, personalized support, and targeted materials. The program includes the following components for those with a chronic condition: • Chronic condition-specific coaching • Pre- and post-discharge calls	**For OAP,** **HSA OAP,** **LCP** **and HSA LCP Products: Included in Medical Access Fee**

	• Lifestyle management coaching: stress, weight management and tobacco cessation • Treatment decision support and coaching	

Motivate*Me*® Incentives Program	The Motivate*Me* incentive program allows Counties 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 Contractor 's health improvement programs and activities that focus on prevention, lifestyle and behavior modification and disease management. Participating Members track their incentive activity online and earn rewards as has been designated per the County's annual elections. Reward types include: HRA and Healthy Awards Account fund deposits, debit and/or gift cards, and County self-administered awards such as HSA fund deposits, healthcare premium adjustment and payroll deposit.	
	Healthy Pregnancy, Healthy Babies® Package - includes reward incentives for Employees participating in the Healthy Pregnancy, Healthy Babies® clinical program.	**For OAP,** **HSA OAP,** **HSA LCP** **and LCP Products: Included in Medical Access Fee**
One Guide	The One Guide advocacy solution utilizes a multimodal approach to support members and help them successfully navigate the health care system. members are serviced by personal guides that include frontline service staff, as well as clinicians and non-clinician support staff from our medical, behavioral and pharmacy programs. In addition to connecting with personal guides via telephone, members can also interact with personal guides via the click-to-chat feature on myCigna.com (web and app), enabling members to engage with Contractor and One Guide in the way in which they prefer. One Guide helps simplify and strengthen the connection between members, their benefit plan, and their overall health and well-being. Through personalized and relevant messaging, One Guide proactively engages members with clear ways to save money, stay healthy, and improve health outcomes that lead to a healthy lifestyle. One Guide offers:	**For OAP,** **HSA OAP,** **HSA LCP** **and LCP Products:** **$1.55/employee/month Included in Medical Access Fee**

	• 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.	
Transparency in Coverage and Consolidated Appropriations Act, 2021	Contractor will make available an internet-based self-service tool for use by Members, as well as certain data in machine-readable file format on a public website, as required under the Transparency in Coverage rule. Members can access the cost estimator tool on myCigna.com. Updated machine-readable files can be found on Cigna.com and/or CignaForCountys.com on a monthly basis. Pursuant to Consolidated Appropriations Act (CAA), Section 106, Contractor will submit certain air ambulance claim information to the Department of Health and Human Services (HHS) in accordance with guidance issued by HHS. Subject to change based on government guidance for CAA Section 204, Contractor will submit certain prescription drug and health care spending information to HHS through Plan Lists Files (P1-P3) and Data Files (D1-D8) (D1-D2 for Countys without integrated pharmacy product) aggregated at the Market Segment and State level, as outlined in guidance.	**Included in Medical Administration Fee**
Omada Diabetes and Hypertension Program	Contractor will facilitate the offering of the Omada Diabetes and Hypertension Program to County's eligible Members (fees include devices/supplies).	**Hypertension Condition* $53.00 Per Participant Per Month Program Fee** **Diabetes Condition $82.00 Per Participant Per Month Program Fee**

		Diabetes and Hypertension Conditions $91.00 Per Participant Per Month Program Fee ***NOTE: Members participating in both DPP and Hypertension programs (member having both conditions), will be charged the fees from the DPP program as well as an incremental fee to cover the Hypertension condition of $15.00 Per Participant Per Month.**

Health Improvement Fund		
Health Improvement Fund	For clinical/wellness/behavioral programs offered by Contractor that are purchased, Contractor will establish a Health Improvement Fund in the amount of $150,000.00. This fund will be used to defray the cost of Contractor designated and arranged health and wellness improvement programs (e.g. biometric screenings, flu shots) for Employees of County and to reward participation in these programs. The Health Improvement Fund is a one-time credit to be used from January 1, 2024-December 31, 2024. Unused funds cannot be rolled over and Contractor must pre-approve use of the Health Improvement Fund. The Health Improvement Fund shall be extinguished upon notice of termination of the Agreement and any fund amount not used prior to the notice of termination of the Agreement shall only be available to County for the purpose of funding the cost of those reimbursable services provided prior to such notice of termination.	

APPROVED

By Boulder County Attorney as to form (apg) at 1:33 pm, Sep 16, 2024

Exhibit D – Services

BANKING AND ADMINISTRATION		
Excluding Health Savings Account		
	Furnishing Contractor's standard Bank Account activity data reports to County as and when agreed upon. Contractor's administration of the Plan does not include performing obligations, if any, under state escheat or unclaimed property laws. It is County's responsibility to determine the extent to which these laws may apply to the Plan and to comply with such laws.	**All Products**
	If County has elected, pursuant to section 63 of the New York Health Care Reform Act of 1996 (section 2807-t of the Public Health Law) ("the Act"), to pay the assessment on covered lives set forth in section 63 and has consented to the conditions set forth in section 63, Contractor shall file such forms and pay such surcharge and assessment on covered lives on behalf of County through the Bank Account to the extent set forth in section 63. Such obligation shall end immediately upon County's failure to provide any information required by Contractor to fulfill this obligation, the failure to comply with any requirement imposed upon County pursuant to the Act or the failure of County to sufficiently fund the Bank Account. In addition, where permitted and agreed to by Contractor, Contractor will file applicable forms and pay on behalf of County and/or the Plan any assessment, surcharge, tax or other similar charge which is required to be made by County and/or the Plan based on covered lives and/or paid claims or otherwise in accordance with and as required by other applicable state and/or federal laws and regulations and the Bank Account will be charged for any such payments made by Contractor. Contractor's obligation to pay on behalf of County shall end immediately upon County's failure to sufficiently fund the Bank Account.	**All Medical Products**
CLAIM ADMINISTRATION		
Excluding Health Savings Account		
	Calculate benefits, check and/or electronic payments disbursed from the Bank Account. Bank Account payments will appear in County's standard Bank Account activity data reports.	**All Products**
	Contractor's generic claim forms are made available to County and eligible individuals.	**All Products**
	Contractor'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 Contractor's book of business internal audits of plan benefit payments on a random sample basis.	**All Products**
	Claim control procedures reported annually in Service Organization Controls (SOC) 1 Reports issued in accordance with American Institute of Certified Public Accountants Statement on Standards for Attestation Engagements (AICPA SSAE) No. 18 Report (or any applicable successor thereto).	**All Products**
	Respond to Insurance Department complaints.	**All Products**
	Designated toll-free telephone line for Member and Provider calls to Contractor Service Centers.	**All Products**
	Member Explanation of Benefit ("**EOB**") statements including, when applicable, notice of denied claims, denial reason(s) and appeal rights.	**All Products (excluding Pharmacy)**
	Verify enrollment and eligibility using Member information submitted by County and/or its authorized agent.	**All Products**
Medical Only		
	Contractor's enrollment methods are made available to County for enrolling individuals into the Plan.	**All Medical Products**
	Contractor's standard ID card with toll-free telephone number are prepared for Members.	**All Medical Products**
	Administration of subrogation/conditional Claim Payment (terms described in Exhibit E).	**All Medical Products**
HEALTH SAVINGS ACCOUNT		
Administration		
	Provision of Health Savings Account: Contractor shall provide to County enrollment materials for Health Savings Accounts ("**HSA**") at a bank or other authorized entity with which Contractor contracts (the "Bank Vendor") for County's Employees enrolled in an eligible High Deductible Health Plan ("**HDHP**"). Contractor and/or the Bank Vendor shall provide to County's eligible Employees who open an HSA ("**HSA Account Holder**") telephonic and Internet customer service, debit cards, HSA checks (option made available to HSA account holders from the bank) to access HSA funds, required IRS forms such as the 1099 and 5498 and access to Individual Summary Statements that reflect account activity. Contractor shall provide to County its standard reports of aggregate non-identifiable information concerning the administration of the HSA.	**HSA Product**
	Claim Forwarding: Each HSA Account Holder may elect to have claims not payable under the HDHP paid from funds in the Account Holder's HSA, to the extent that funds are available in such account ("**Claim Forwarding**"), whether or not the expense is a qualified IRS medical expense.	**HSA Product**

	Claim Forwarding is only available for payments due medical providers. Claim Forwarding is not available for pharmacy expenses.	
	Use of HSA: HSA Account Holders are solely responsible to use HSA funds as permitted by law, including Section 223(a) of the Internal Revenue Code, to qualify for applicable tax benefits.	**HSA Product**
	Enrollment in High Deductible Health Plan - County acknowledges that its prompt furnishing of complete and accurate HDHP eligibility and benefit information, including prompt depositing of contributions, is essential to the timely and efficient administration of its Employees' health savings accounts and impacts bank ability to respond to Employee account withdrawals or payments. It is understood that Employee HDHP coverage terminations, including default terminations whether or not caused by County failure to reconcile Employee eligibility when so requested by Contractor, could result in health savings account tax consequences for the employee and/or in interrupting the Employee's eligibility to make health savings account contributions.	**HSA Product**
	Access Codes. County shall ensure that each authorized user establishes an Access Code for access to the Online Portal. County shall further ensure that authorized users safeguard all Access Codes and shall be responsible for all use of Access Codes.	**HSA Product**
	Online Portal. Access to the Online County Portal delivered by the Bank Vendor shall be in accordance with such manuals, training materials, terms of use, administrative control procedures, terms and conditions, and other information as shall be provided to County from time to time and County shall ensure access to Online County Portal complies with any such information and materials. County's authorized users may be assigned different levels of access. Some of the functions that County may access on the Portal are: 1) view reserve funding account balance and activity; 2) perform manual funding of Employee bank accounts; 3) download various reports; 4) learn of upcoming changes in HSA rules; 5) use the links and tools for HSA education and additional information.	**HSA Product**
	County agrees that any access, transaction, or business conducted using the Online County Portal is presumed by Contractor to have been in compliance with HSA Plan Administration under Section 223(a) of the Internal Revenue Code. Any unauthorized use of the Online County Portal or any Access Code shall be solely the responsibility of the County.	**HSA Product**
County Responsibilities		
	HSA Contributions - County will facilitate pre-tax payroll contributions by HSA Account Holders. County may elect to make its own contributions to HSA. County shall send HSA Account Holder contributions plus any County contributions directly to the Bank Vendor.	**HSA Product**
	Eligibility and Enrollment - County is responsible for distributing to eligible Employees the HSA enrollment application and documents provided to County by Contractor and the Bank Vendor.	**HSA Product**

	County will submit completed HSA enrollment applications to Contractor 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.	
	Information Verification - County shall verify information provided to Contractor 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 – Contractor pays Bank Vendor to administer the HSA Accounts.	**HSA Product**
	Bank Fees to Accountholder – It is understood that there are separate account fees charged each HSA Account Holder by the Bank Vendor pursuant to terms communicated to HSA Account Holders through separate bank documents.	**HSA Product**
	Confidentiality – It is understood that the confidentiality of employee information provided directly by the Employee or County (on Employee's behalf) to the Bank Vendor is governed by the terms and provisions of the agreement between the employee and the Bank Vendor, and neither the Employee nor County shall have any recourse against Contractor for any breach thereof. To the extent that County, in satisfying its obligations under this Agreement, is required to provide confidential information to Contractor, it is understood that the terms of the Agreement will apply. Contractor will ensure that confidential information will be securely handled and maintained in accordance with all Applicable Laws and/or regulations.	**HSA Product**
Termination		
	Termination of HSA Account Holder's HDHP or of Services Under This Exhibit – Free Agents: In the event of the termination of an HSA Account Holder's HDHP coverage through Contractor,	**HSA Product**

	the HSA Account Holder becomes a "**Free Agent**". Similarly, should Contractor's HSA services under this Exhibit be terminated for any reason, either for a specific Employee, or for the County as a whole, the affected HSA Account Holders shall from that point on be Free Agents. For Free Agents: (1) Contractor shall no longer provide HSA services; (2) Any terms of this Exhibit shall no longer be applicable; (3) HSA shall continue to be maintained by the Bank Vendor directly not in its role as a Contractor to Contractor; (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 Contractor receives notice of such termination.	**HSA Product**
Effect of HSA Plan on ASO Agreement Terms		
	All applicable provisions of the ASO Agreement apply to the HSA Services described in this Exhibit. In the event of a conflict between any provision of the ASO Agreement and the terms of the Exhibit with respect to the HSA services, the terms of this Exhibit shall govern.	**HSA Product**
PLAN BOOKLET		
	Prepare and make accessible Member benefit booklet drafts to County.	**All Products**
UNDERWRITING SERVICES		
	5500 Schedule C reporting.	**All Products**
	5500 Schedule A or Annual Reconciliation Disclosure reporting (when applicable)	**All Products**
	Contractor's standard Underwriting services: a) benefit design analysis b) projected cost analysis.	**All Products**
HIPAA INDIVIDUAL RIGHTS		
	Handling of requests from Members for access to, amendment and accounting of protected health information, and requests for restrictions and alternative communications as required under federal HIPAA law and regulations, as set out in this Agreement and its Exhibits.	**All Products**

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

	under County's stop loss policy will not be available for stop loss policy administration, County is responsible for verifying any such required information with its stop loss carrier.	
	Contractor's standard Individual Summary Statements for applicable participating Members.	**HSA Products**
MEMBER EXTERNAL REVIEW PROGRAM		
	Contractor 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 Contractor on a random basis. If County has chosen not to participate in this program, the County may be responsible for making other arrangements to meet the Patient Protection and Affordable Care Act (PPACA) external review requirements.	**All Medical Products**
MEDICAL MANAGEMENT SERVICES		
	CONTRACTOR 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 Contractor's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products**
	Case Management, a service designed to provide assistance to a Member who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support.	**All Medical Products**
	Assist providers with resources and tools to enable them to develop long term treatment plans in the management of chronic or catastrophic cases.	**All Medical Products**
	The Cigna HealthCare Healthy Babies Program is an educational program which provides Member with prenatal care education and resources to help them better manage their pregnancy. Other benefits of this program include the Health Information Line, high risk maternity and pregnancy information on myCigna.com.	**All Medical Products**
	HealthCare Cost and Quality tools available on myCigna.com and myCigna mobile app.	**All Medical Products**
	A panel of physicians and other clinicians to assess the safety and effectiveness of new and emerging medical technologies. The panel meets monthly to review and update coverage policies.	**All Medical Products**
	Health Information Line is a service that provides twenty-four (24) hour toll free access to nurses who provide convenient and confidential services. Health Information Line nurses can help guide Members in finding the right care, make informed decisions about symptom-based health issues the	**All Medical Products**

	Member is experiencing when they call the Health Information Line and recommend appropriate settings for care. Health Information Line nurses can help inform and educate Members about a wide variety of health and medical information, including access to a library of English and Spanish podcasts.	
	Cigna LifeSOURCE Transplant Network® contracts with more than one hundred seventy (170) independent transplant facilities which includes over eight hundred (800) transplant programs and provides access to solid organ and bone marrow/stem cell transplantation while improving cost containment and reducing financial risk.	**All Medical Products**
	A health education program that delivers mailings to Members with certain conditions.	**All Medical Products**
	Behavioral health services are provided/arranged by a Contractor affiliate (details available upon request), including utilization review and case management for inpatient in-network behavioral health services.	**OAP,** **HSA OAP,** **LCP** **and HSA LCP Products:** **(CA/VI Members)**
	Behavioral health services are provided/arranged by a Contractor affiliate (details available upon request), including utilization review and case management for both inpatient and outpatient, in-network behavioral health services.	**OAP,** **HSA OAP,** **LCP** **and HSA LCP Products:** **(Non-CA/VI Members)**
	Implement a quality oversight process that includes monitoring of utilization management performance measurements and a continuous quality improvement process when warranted.	**All Medical Products**

	Transition of care services to allow Members with defined conditions to continue treatment with non-Participating Providers after enrollment for continued uninterrupted care for a limited time.	**All Medical Products Except Comprehensive and Indemnity**
	Focused utilization management of outpatient procedures and identification of appropriate alternatives. Administered in accordance with Contractor's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products with Care Management Preferred**
NETWORK MANAGEMENT SERVICES		
	Contractor, 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, Contractor 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 Contractor's credentialing requirements and ensure that third-party network vendors credential/re-credential Participating Providers in accordance with Contractor's requirements;	**All Medical Products**
	Monitor Participating Provider compliance with protocols and procedures for quality, Member satisfaction, and grievance resolution;	**All Medical Products**
	Facilitate the identification of Participating Providers by Members; and	**All Medical Products**
	Designated toll-free telephone line for Member and Provider calls to Contractor Service Centers.	**All Medical Products**
	Access to virtual on-demand urgent care, scheduled primary care, and scheduled behavioral health visits via phone or video, and virtual dermatology visits via secure messaging. Members may access this service via myCigna.com or the myCigna app.	**All Medical Products**
BEHAVIORAL HEALTH		
	Contractor has contracted with an affiliate (details available upon request) to provide or arrange for the provision of managed in-network behavioral health services, the affiliate is a Participating Provider, and is reimbursed primarily on a monthly fixed fee basis This fixed fee for behavioral health services will be paid as claims and will appear in County's monthly reporting and on	**These services are included in the following products:**

	financial documents. Such payments will be at the relevant monthly rates then in effect. The monthly rates paid to the affiliate vary depending on geographic location of Members and on benefit design, and may be subject to change. The rates will be made available upon request. The fixed fee also includes applicable lifestyle management 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 behavioral health administrative fee (including the applicable lifestyle management programs and a cognitive behavioral modification program) will be paid from the Bank Account as claims and will appear in County's monthly reporting.	**OAP,** **HSA OAP,** **LCP** **and HSA LCP Products**
EVERNORTH CARE GROUP SERVICES		
	The Cigna HealthCare of Arizona, Inc. staff model Evernorth Care Group (formerly known as Cigna Medical Group or "CMG") is a multispecialty participating provider group located in metropolitan Phoenix, Arizona. Evernorth Care Group'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 an Evernorth Care Group facility or provider even if they do not reside in Arizona (as when traveling). Plan Participants utilizing Cigna participating provider networks in Arizona may access certain specialty and/or ancillary services (such as urgent care services) through the Evernorth Care Group system. For covered services provided to Participants, Evernorth Care Group is paid at the rates in effect at the time of service (as may be revised from time to time). Representative rates for routinely performed services are available upon request. If the Plan requires or allows Participants to select a primary care provider ("**PCP**"), Phoenix area Participants who do not select a PCP during open enrollment may be assigned to or otherwise encouraged to consider an Evernorth Care Group PCP. Evernorth Care Group has established collaborative referral relationships with specialty and ancillary providers in Cigna's participating provider networks, which includes affiliated entities.	**All Medical Products**

	Evernorth Care Group may also receive applicable performance-based incentive payments for its participation in programs designed to improve quality, patient safety and affordability. The incentive payments that Evernorth Care Group may receive will be determined using the same performance measures and reward formula as used in determining the incentive payments made to similarly situated non-Cigna affiliated provider entities.	