City of Santa Fe

AGENDA

REGULAR MEETING OF THE QUALITY OF LIFE COMMITTEE
DECEMBER 07, 2022
5:00 PM
COUNCIL CHAMBERS
CITY HALL
201 LINCOLN AVENUE

PROCEDURES FOR QUALITY OF LIFE COMMITTEE MEETING

Viewing: Members of the public may stream the meeting live on the City of Santa Fe's YouTube channel at https://www.youtube.com/user/cityofsantafe. The YouTube live stream can be accessed at this address from most smartphones, tablets, or computers.

Written Public Comment: Members of the public may submit written comments on legislation by clicking on the comment bubble to the right of the meeting on the public portal at https://santafe.primegov.com/public/portal three hours prior to the start of the meeting.

The agenda and packet for the meeting will be posted at https://santafe.primegov.com/public/portal.

1. **CALL TO ORDER**

2. **ROLL CALL**

3. **APPROVAL OF AGENDA**

4. **APPROVAL OF CONSENT AGENDA**

5. **PRESENTATIONS**

a. Update Regarding Police Department Recruitment and Staffing Levels (Chief Paul Joye, Police Chief: pmjoye@santafenm.gov, 505-955-5355)

b. Presentation of the Language Accessibility Study Conducted by Pivot Access (Kristine Bustos-Mihelcic, City Clerk and Director of Community Engagement: kmmihelcic@santafenm.gov, 505-955-6327; Julie Sanchez, Director, Youth and Family Services Divison: jjsanchez@santafnm.gov, 505-955-6678; Curt Means, Pivot Access)

6. **ACTION ITEMS: CONSENT**

a. Approval of Minutes for the October 19, 2022 Quality of Life Committee Meeting (Loretta Olguin, Business Operations Manager: lsolguin@santafenm.gov, 505-955-6334)

b. Approval of Minutes for the November 2, 2022 Quality of Life Committee Meeting (Loretta Olguin, Business Operations Manager: lsolguin@santafenm.gov, 505-955-6334)

c. Request for Approval of American Rescue Plan Act (ARPA) Recovery Funds Subrecipient Contract with the New Mexico Coalition to End Homelessness in the Total Amount of $600,000 for Consuelo's Place Shelter Under the First Statutory Category – to Respond to the COVID-19 Public Health Emergency or its Negative Economic Impacts. (Cody Minnich, Housing Grant Manager: cjminnich@santafenm.gov, 505-955-6574)

Committee Review
Finance Committee: 11/28/2022
Quality of Life Committee: 12/07/2022
Governing Body: 12/14/2022

d. Request for Approval of Amendment No.1 to the Phone Maintenance and Support Agreement Item #20-0041 with Altura Communications Solutions to Increase Compensation by $583,959.21 Including Gross Receipts Tax

for Telecommunications Services through December 31, 2025 in the Total Amount of $827,600.07. (Manuel Gonzales, mmgonzales@santafenm.gov, 505-955-5576)

Committee Review:
Finance Committee: 11/28/2022
Quality of Life Committee: 12/072022
Governing Body: 12/14/2022

e. Request for Approval of Amendment No. 1 to Telecommunications Agreement Item #19-0871 with Century Link to Increase Compensation by $45,720 for a Total Amount of $483,595.20 for a Term of Sixty Months with GEO MAX. (Manuel Gonzales, ITT Department Director: mmgonzales@santafenm.gov, 505-955-5576)

Committee Review:
Finance Committee: 11/28/2022
Quality of Life Committee: 12/07/2022
Governing Body: 12/14/2022

f. Request for the Approval of FY 2023 Grant Contract with Corporation for National and Community Service in the Total Amount of $89,058 for the Foster Grandparent and Retired Senior Companion Volunteer Programs. (Anya Alarid, Volunteer Program Manager: aalarid@santafenm.gov 505-955-4744)

Committee Review:
Finance Committee: 11/28/2022
Quality of Life Committee: 12/7/2022
Governing Body: 12/14/2022

g. Request for Approval of a Grant Agreement with New Mexico Department of Transportation in the Total Amount of $83,749 for the Funding of Projects: End Driving While Impaired (ENDWI); Buckle Up (BKLUP)/Click it or Ticket (CIOT); Selective Traffic Enforcement Program (STEP)/Summer Enforcement Period. (Lieutenant Jose Gonzales Support Operations and Traffic: jcgonzales@santafenm.gov)

1. Request for Approval of a Budget Amendment Resolution in the Total Amount of $83,749 to Increase the General Fund Budget to Fund Various Traffic Enforcement Projects with New Mexico Department of Transportation.

Committee Review:
Finance Committee: 11/28/2022
Quality of Life Committee: 12/07/2022
Governing Body Committee: 12/14/2022

h. Request for Approval of Amendment No. 6 to Administrative Services Agreement #15-0757 with Cigna Health and Life Insurance to Extend the Term to June 30, 2025 for City of Santa Fe Employer Sponsored Health and Life Insurance Benefits. (Alvin Valdez Benefits and Wellness Supervisor, aavaldez1@santafenm.gov, 505-955-6075 and Bernadette Salazar, Human Resources Director, bjsalazar@santafenm.gov, 505-955-6591)

Committee Review:
Finance Committee: 11/28/2022
Quality of Life Committee: 12/7/2022
Governing Body 12/14/2022

i. Request for Approval of an American Rescue Plan Act (ARPA) Recovery Funds Sub-Recipient Contract in the Total Amount of $797,600 for Jobs Training and Work-Based Learning Under the 2.10 Assistance to Unemployed or Underemployed Workers Statutory Category; to Respond to the COVID-19 Public Health Emergency or its Negative Economic Impacts (Rich Brown, Community & Economic Development Director: rdbrown@santafenm.gov, 505-955-6626).

Committee Review:
Finance Committee: 11/28/2022
Quality of Life Committee: 12/7/2022
Public Works Committee: 12/12/2022
Economic Development Advisory Committee: 12/14/2022
Governing Body: 12/14/2022

j. CONSIDERATION OF RESOLUTION NO 2022-__ (Councilor Cassutt and Councilwoman Villarreal)
A Resolution in Support of the Appropriation of Funds by the New Mexico Legislature for New Mexico-Grown Fresh Fruits and Vegetables for School and Senior Meals Programs and Related Education Programs for Schools and Farmers**.** (Jesse Guillen, Policy and Innovation Manager: jbguillen@santafenm.gov, 505-955-6518)

Committee Review:
Governing Body (Introduced): 11/09/2022
Quality of Life Committee: 12/07/2022
Governing Body: 12/14/2022

k. CONSIDERATION OF RESOLUTION NO. 2023-__. (Mayor Webber, Councilor Chavez)
A Resolution Relating to Firearms; Recognizing That Certain City Properties are Used for School-Related Activities, Which Makes the Carrying of a Deadly Weapon on Such Properties a Fourth-Degree Felony Pursuant to NMSA 1978, Section 30-7-2.1; and Directing the City Manager to Work with Staff to Post Notice on Such Facilities. (Kyra Ochoa, Community Health and Safety Department Director: krochoa@santafenm.gov)

Committee Review:
Introduced: 11/30/22
Quality of Life Committee: 12/7/22
Public Works and Utilities Committee: 12/12/22
Finance Committee: 01/03/23
Governing Body: 01/11/23

l. CONSIDERATION OF BILL NO. 2022-__. (Councilor M. Garcia, Councilor Cassutt)
An Ordinance Relating to Electric Bicycles; Amending Section 12-1-6 of the Uniform Traffic Ordinance ("UTO") to Include Electric Bicycles in the Definition of Bicycle; Amending Section 12-1-40 of the UTO to Delineate Electric Bicycles From Motor Vehicles; Amending Section 12-1-88 of the UTO to Specify That an Electric Bicycle is Not a Vehicle; Amending Section 12-8-1 of the UTO to Prohibit Anyone Under the Age of Sixteen From Riding a Class 3 Electric Bicycle; Amending Section 12-8-10 of the

UTO to Regulate and Establish a Speed Limit for Electric and Manually-Propelled Bicycles on City Sidewalks; Amending Section 12-8-15 of the UTO to Remove the Prohibition for Bicycles to Ride on a Street Adjacent to a Sidewalk or Path When Bicycles are Required to Use the Sidewalk or Street; Creating a New Section 12-8-18 of the UTO to Make it an Offense to Enhance the Speed Capabilities of an Electric Bicycle; Amending Section 12-8-23 of the UTO to Raise the Maximum Fine for Violation of Certain Provisions from Twenty-Five Dollars to One Hundred Dollars; and Amending SFCC 1987 Section 23-5.1 to Amend the Definition of Bicycle to Include Electric Bicycles, and to Regulate the Use of Electric Bicycles on City Roads. (Romella Glorioso-Moss; Project Administrator: rsglorioso-moss@santafenm.gov, 505-955-6623; Kevin Nault, Assistant City Attorney: klnault@santafenm.gov)

Committee Review:
Governing Body (Introduced): 08/31/2022
Governing Body (Public Comment): 09/14/2022
Bicycle and Pedestrian Advisory Committee: 10/13/2022
Quality of Life Committee: 10/19/2022
Bicycle and Pedestrian Advisory Committee: 11/10/2022
Quality of Life Committee: 12/7/2022
Public Works and Utilities Committee: 12/12/2022
Finance Committee: 01/03/2023
Governing Body (Public Hearing): 01/11/2023

7. **INTRODUCTION OF LEGISLATION**

8. **MATTERS FROM STAFF**

9. **MATTERS FROM THE COMMITTEE**

10. **MATTERS FROM THE CHAIR**

11. **NEXT MEETING: Wednesday, January 4, 2023**

12. **ADJOURN**

Persons with disabilities in need of accommodations, contact the City Clerk's office at 955-6521, five (5) working days prior to meeting date.

City of Santa Fe

MINUTES

REGULAR MEETING OF THE QUALITY OF LIFE COMMITTEE
OCTOBER 19, 2022
5:00 PM
VIRTUAL MEETING

1. CALL TO ORDER

The Quality of Life Committee meeting was called to order by Chair Cassutt at 5:04 pm on Wednesday, October 19, 2022, in the City Council Chambers.

2. ROLL CALL

Members Present:
Councilor Amanda Chavez
Councilor Lee Garcia
Councilor Michael Garcia
Councilor Jamie Cassutt
Councilor Renee Villarreal

Members Excused:
None

Others Attending:
Loretta Olguin, Clerk

3. APPROVAL OF AGENDA

Ms. Olguin stated that item D had been reomoved by sponsor Councilor Michael Garcia, for additional discussion. It will come back to this Committee at a later date.

MOTION: Councilor Michael Garcia moved, seconded by Councilor Renee Villarreal, to approve the as amended.

VOTE: The motion was approved on the following Roll Call vote:

For: Councilor Amanda Chavez, Councilor Lee Garcia, Councilor Michael Garcia, Councilor Jamie Cassutt, Councilor Renee Villarreal

Against: None

4. APPROVAL OF CONSENT AGENDA

MOTION: Councilor Renee Villarreal moved, seconded by Councilor Amanda Chavez, to approve the as amended.

VOTE: The motion was on the following Roll Call vote:

For: Councilor Amanda Chavez, Councilor Lee Garcia, Councilor Michael Garcia, Councilor Jamie Cassutt, Councilor Renee Villarreal

Against: None

Items H and J were pulled for discussion by Councilor Villarreal.

5. **APPROVAL OF MINUTES**

6. **PRESENTATION**

   a. Update on Airport Road Main Street Urban Commercial Corridor Progress (Elizabeth Camacho, Economic Development & Communication Adminstrator: excamacho@santafenm.gov; Miguel Acosta, macosta.csf@gmail.com)

7. **ACTION ITEMS: CONSENT**

   a. Approval of Minutes for the October 5, 2022 Quality of Life Committee Meeting (Loretta Olguin, Business Operations Manager: lsolguin@santafenm.gov, 505-955-6334)

MOTION: Councilor Renee Villarreal moved, seconded by Councilor Amanda Chavez, to approve the minutes as presented.

VOTE: The motion was on the following Roll Call vote:

For: Councilor Amanda Chavez, Councilor Lee Garcia, Councilor Michael Garcia, Councilor Jamie Cassutt, Councilor Renee Villarreal

Against: None

b. Request for Approval of North Central New Mexico Economic Development District, Non-Metro Area Agency on Aging (AAA) Federal and State Sub-Award Contract to Provide Services to Eligible Clientele that Receive Transportation, Nutrition, and In-Home Support Services in the Total Amount of $877,035.08, Term Ending June 30, 2023. (Gino Rinaldi, Senior Services Director: earinaldi@santafenm.gov, 505-955-4710)

Committee Review:
Finance Committee: 10/17/2022
Quality of Life: 10/19/2022
Governing Body: 10/26/2022

MOTION: Councilor Renee Villarreal moved, seconded by Councilor Amanda Chavez, to approve the contract as presented.

VOTE: The motion was on the following Roll Call vote:

For: Councilor Amanda Chavez, Councilor Lee Garcia, Councilor Michael Garcia, Councilor Jamie Cassutt, Councilor Renee Villarreal

Against: None

c. Request for the Approval of State of New Mexico Aging and Long Term Services Department Capital Appropriation Project Grant Agreement A20E5290 in the Total Amount of $827,000 for the Purchase of Mary Esther Gonzales Senior Center Vehicles, Term Ending June 30, 2024. (Gino Rinaldi, Senior Services Director: earinaldi@santafenm.gov, 505-955-4710)

Committee Review:
Finance Committee: 10/17/2022
Quality of Life: 10/19/2022

Governing Body: 10/26/2022

MOTION: Councilor Renee Villarreal moved, seconded by Councilor Amanda Chavez, to approve the grant as presented.

VOTE: The motion was on the following Roll Call vote:

For: Councilor Amanda Chavez, Councilor Lee Garcia, Councilor Michael Garcia, Councilor Jamie Cassutt, Councilor Renee Villarreal

Against: None

d. CONSIDERATION OF BILL NO. 2022-__. (Councilor M. Garcia)
An Ordinance Relating to Electric Bicycles; Amending Section 12-1-6 of the Uniform Traffic Ordinance ("UTO") to Include Electric Bicycles in the Definition of Bicycle; Amending Section 12-1-40 of the UTO to Delineate Electric Bicycles From Motor Vehicles; Amending Section 12-1-88 of the UTO to Specify That an Electric Bicycle is Not a Vehicle; Amending Section 12-8-1 of the UTO to Prohibit Anyone Under the Age of Sixteen From Riding a Class 3 Electric Bicycle; Amending Section 12-8-10 of the UTO to Regulate and Establish a Speed Limit for Electric and Manually-Propelled Bicycles on City Sidewalks; Amending Section 12-8-15 of the UTO to Remove the Prohibition for Bicycles to Ride on a Street Adjacent to a Sidewalk or Path When Bicycles are Required to Use the Sidewalk or Street; Creating a New Section 12-8-18 of the UTO to Make it an Offense to Enhance the Speed Capabilities of an Electric Bicycle; Amending Section 12-8-23 of the UTO to Raise the Maximum Fine for Violation of Certain Provisions from Twenty-Five Dollars to One Hundred Dollars; and Amending SFCC 1987 Section 23-5.1 to Amend the Definition of Bicycle to Include Electric Bicycles, and to Regulate the Use of Electric Bicycles on City Roads. (Romella Glorioso-Moss; Project Administrator: rsglorioso-moss@santafenm.gov, 505-955-6623; Kevin Nault, Assistant City Attorney: klnault@santafenm.gov)

Committee Review:
Governing Body (Introduced): 08/31/2022
Governing Body (Public Comment): 09/14/2022
Bicycle and Pedestrian Advisory Committee: 10/13/2022

Quality of Life Committee: 10/19/2022
Bicycle and Pedestrian Advisory Committee: 11/10/2022
Quality of Life Committee: 12/7/2022
Public Works and Utilities Committee: 12/12/2022
Finance Committee: 01/09/2023
Governing Body (Public Hearing): 01/11/2023

MOTION: Councilor Renee Villarreal moved, seconded by Councilor Amanda Chavez, to approve the bill as presented.

VOTE: The motion was on the following Roll Call vote:

For: Councilor Amanda Chavez, Councilor Lee Garcia, Councilor Michael Garcia, Councilor Jamie Cassutt, Councilor Renee Villarreal

Against: None

e. CONSIDERATION OF RESOLUTION NO. 2022-__. (Councilor Cassutt, Councilor Chavez, Councilwoman Villarreal, Councilor Michael Garcia)
A Resolution Adopting the City of Santa Fe Multimodal Transition Plan. (Erick Aune, MPO Officer: ejaune@santafenm.gov, 955-6664)

Committee Review
Governing Body (Introduced): 10/12/2022
Bicycle and Pedestrian Advisory Committee: 10/13/2022
Quality of Life Committee: 10/19/2022
Public Works and Utilities Committee: 10/24/2022
Finance: 10/31/2022
Governing Body: 11/9/2022

MOTION: Councilor Renee Villarreal moved, seconded by Councilor Amanda Chavez, to approve the resolution as presented.

VOTE: The motion was on the following Roll Call vote:

For: Councilor Amanda Chavez, Councilor Lee Garcia, Councilor Michael Garcia, Councilor Jamie Cassutt, Councilor Renee Villarreal

Against: None

f. CONSIDERATION OF RESOLUTION NO. 2022-__. (Councilwoman Villarreal and Councilor Rivera)
A Resolution Extending the Term of the Community Health and Safety Task Force Until June 30, 2023, to Allow the Task Force to Complete It's Duties and Responsibilities. (Julie Sanchez, Youth and Family Services Division Director: jjsanchez@santafenm.gov, 955-6678)

Committee Review:
Governing Body (Introduced): 10/12/2022
Quality of Life Committee: 10/19/2022
Governing Body: 10/26/2022

MOTION: Councilor Renee Villarreal moved, seconded by Councilor Amanda Chavez, to approve the resolution as presented.

VOTE: The motion was on the following Roll Call vote:

For: Councilor Amanda Chavez, Councilor Lee Garcia, Councilor Michael Garcia, Councilor Jamie Cassutt, Councilor Renee Villarreal

Against: None

g. CONSIDERATION OF RESOLUTION NO. 2022-__. (Councilwoman Villarreal, Councilor Rivera, and Councilor Cassutt)
A Resolution Supporting the Santa Fe Public Schools ("SFPS") in Adopting a Community Schools Model and Directing the City Manager to Support the City's Continued Collaboration and Participation with the SFPS's Community Schools Steering Committee. (Julie Sanchez, Youth and Family Services Division Director: jjsanchez@santafenm.gov, 505-955-6678)

Committee Review:
Governing Body (Introduced): 10/12/2022
Quality of Life Committee: 10/19/2022
Governing Body: 10/26/2022

MOTION: Councilor Renee Villarreal moved, seconded by Councilor Amanda Chavez, to approve the resolution as presented.

VOTE: The motion was on the following Roll Call vote:

For: Councilor Amanda Chavez, Councilor Lee Garcia, Councilor Michael Garcia, Councilor Jamie Cassutt, Councilor Renee Villarreal

Against: None

h. CONSIDERATION OF RESOLUTION NO. 2022-__. (Councilor Chavez, Councilor Lindell, Councilor Lee Garcia, Councilor Cassutt, Councilwoman Villarreal)
A Resolution Creating a One-Year Pilot Program to Encourage and Incentivize Employers to Pay for Employee Parking in City of Santa Fe ("City") Parking Facilities at Sandoval Street, the Santa Fe Community Convention Center, and the Railyard. (Regina Wheeler, Public Works Department Director: rawheeler@santafenm.gov, 505-955-6622)

Committee Review:
Governing Body (Introduced): 10/12/2022
Quality of Life Committee: 10/19/2022
Public Works and Utilities Committee: 10/24/2022
Finance Committee: 10/31/2022
Governing Body: 11/09/2022

MOTION: Councilor Michael Garcia moved, seconded by Councilor Amanda Chavez, to approve the resolution as amended.

VOTE: The motion was on the following Roll Call vote:

For: Councilor Amanda Chavez, Councilor Lee Garcia, Councilor Michael Garcia, Councilor Jamie Cassutt, Councilor Renee Villarreal

Against: None

i. CONSIDERATION OF RESOLUTION NO 2022-__. (Councilor Romero-Wirth, Councilor Cassutt and Councilwoman Villarreal)
A Resolution Calling on the New Mexico State Legislature to Take Action During the 2023 Legislative Session to End Driver's License Suspensions for Failure to Pay and Failure to Appear. (Kyle Hibner, City Prosecutor: kjhibner@santafenm.gov, 955-5195)

Committee Review:
Governing Body (Introduced): 10/12/2022
Quality of Life Committee: 10/19/2022
Governing Body: 10/26/2022

MOTION: Councilor Renee Villarreal moved, seconded by Councilor Michael Garcia, to move the resolution forward with no recommendation.

VOTE: The motion was on the following Roll Call vote:

For: Councilor Amanda Chavez, Councilor Lee Garcia, Councilor Michael Garcia, Councilor Jamie Cassutt, Councilor Renee Villarreal

Against: None

j. CONSIDERATION OF RESOLUTION NO. 2022-__. (Mayor Webber)
A Resolution Establishing City of Santa Fe's Priorities for Consideration by the New Mexico State Legislature During the 56th Legislature – State of New Mexico – First Session, 2023. (Regina Wheeler, Public Works Director: rawheeler@santafenm.gov, 955-6622; Jesse Guillen, Legislation and Policy Innovation Manager: jbguillen@santafenm.gov, 955-6518)

Committee Review:
Finance Committee (Introduced): 10/17/22
Quality of Life Committee: 10/19/22
Public Works and Utilities Committee: 10/24/22
Finance Committee: 10/31/22
Governing Body: 11/09/22

8. **ACTION ITEMS: DISCUSSION**

a. CONSIDERATION OF BILL NO. 2022-__. (Councilor Lindell, Mayor Webber, Councilor Chavez)
An Ordinance Amending Section 12-10-1.10 of the Uniform Traffic Ordinance Governing Mufflers and Emission Control Devices; and Amending Schedule A of the Uniform Traffic Ordinance to Increase Penalties for Muffler Noise Violations. (Matthew Champlin, Deputy Chief of Police: mrchamplin@santafenm.gov, 955-5201)

Committee Review:
Governing Body (Introduced): 09/14/22
Governing Body (Public Comment): 09/28/22
Quality of Life Committee (Postponed): 10/05/22
Quality of Life Committee (Forwarded with No Recommendation): 10/19/22
Public Works and Utilities Committee: 10/24/22 (Postponed)
Public Works and Utilities Committee: 11/7/22 (Forwarded with No Recommendation)
Finance Committee: 11/28/22
Governing Body (Public Hearing): 12/14/22

9. **MATTERS FROM STAFF**

10. **MATTERS FROM THE COMMITTEE**

11. **MATTERS FROM THE CHAIR**

12. **NEXT MEETING: November 02 2022**

13. **ADJOURN**

There being no further business before the Committee, the meeting adjourned at 7:50 pm.

Liaison

Chair

City of Santa Fe

MINUTES

REGULAR MEETING OF THE QUALITY OF LIFE COMMITTEE
NOVEMBER 02, 2022
5:00 PM
VIRTUAL MEETING

1. CALL TO ORDER

The meeting of the Quality of Life Committee was called to order at 5:00 pm on November 2, 2022 by Chair Councilor Cassutt, at City Hall in the City Councilors Chambers.

2. ROLL CALL

Members Present:
Councilor Amanda Chavez
Councilor Lee Garcia
Councilor Michael Garcia
Councilor Jamie Cassutt
Councilor Renee Villarreal

Members Excused:
None

Others Attending:
Kyra Ochoa, Community Services Department Director
Elizabeth Martin, Clerk
Rich Brown, Attendee

3. APPROVAL OF AGENDA

MOTION: Councilor Amanda Chavez moved, seconded by Councilor Renee Villarreal, to approve the as presented.

VOTE: The motion was approved on the following Roll Call vote:

For: Councilor Amanda Chavez, Councilor Lee Garcia, Councilor Michael Garcia, Councilor Jamie Cassutt, Councilor Renee Villarreal

Against: None

4. APPROVAL OF CONSENT AGENDA

MOTION: Councilor Amanda Chavez moved, seconded by Councilor Lee Garcia, to approve the as amended.

VOTE: The motion was on the following Roll Call vote:

For: Councilor Amanda Chavez, Councilor Lee Garcia, Councilor Michael Garcia, Councilor Jamie Cassutt, Councilor Renee Villarreal

Against: None

Chair Cassutt pulled item C from the Consent Agenda for discussion.

Councilor Villarreal pulled item A from the Consent Agenda for corrections.

5. **PRESENTATION**

a. Consuelo's Place: Exploring the Role of Non-Congregate Shelter Beyond the Pandemic (Kyra Ochoa, Director of Community Health and Safety Department: krochoa@santafenm.gov, 505-955-6603; Alexandra Ladd, Director of Affordable Housing: agladd@santafenm.gov, 505-955-6346)

6. **ACTION ITEMS: CONSENT**

a. Approval of Minutes for the October 19, 2022 Quality of Life Committee Meeting (Loretta Olguin, Business Operations Manager: lsolguin@santafenm.gov, 505-955-6334)

MOTION: Councilor Renee Villarreal moved, seconded by Councilor Amanda Chavez, to postpone the minutes until the next meeting.

VOTE: The motion was on the following Roll Call vote:

For: Councilor Amanda Chavez, Councilor Lee Garcia, Councilor Michael Garcia, Councilor Jamie Cassutt, Councilor Renee

Villarreal

Against: None

Councilor Villarreal identified the following issues with the minutes:

Item I on the top of page 9, th the motion and second shown are for the item below, the vote on item J is above it versus below it. Also the votes show Garcia voting but not the first names to show that both Lee Garcia and Michael Garcia voted. There is not vote shown for the Action item regarding the Uniform Traffic Ordinance.

b. Request for the Approval of State of New Mexico Aging and Long Term Services Department Capital Appropriation Project Grant Agreement A20E5288 to Plan, Design, Construct, Equip and Furnish the Mary Esther Gonzales Senior Center, in the Total Amount of $2,484,852, Term Ending June 30, 2024. (Gino Rinaldi, Senior Services Division Director: earinaldi@santafenm.gov, 505-955-4710)

1. Request for Approval of a Budget Amendment Resolution in the Amount of $2,484,852.

Committee Review:
Finance Committee: 10/31/2022
Quality of Life: 11/2/2022
Governing Body: 11/09/2022

MOTION: Councilor Amanda Chavez moved, seconded by Councilor Lee Garcia, to approve the grant as presented.

VOTE: The motion was on the following Roll Call vote:

For: Councilor Amanda Chavez, Councilor Lee Garcia, Councilor Michael Garcia, Councilor Jamie Cassutt, Councilor Renee Villarreal

Against: None

c. Request for Approval of a Budget Adjustment Resolution (BAR) to Move Funds from Fund 350 (ART 4 CIP) to Fund 213 (ART Admin) in the Amount of $414,230 to Fund Various Arts & Culture Initiatives. (Pauline Kanako Kamiyama,pkkamiyama@santafenm.gov, 505-955.6707).

Committee Review:
Arts Commission : 10/17/2022
Finance Committee: 10/31/2022
Quality of Life: 11/02/2022
Governing Body: 11/09/2022

MOTION: Councilor Renee Villarreal moved, seconded by Councilor Amanda Chavez, to approve the budget adjustment resolution (BAR) as amended.

VOTE: The motion was on the following Roll Call vote:

For: Councilor Amanda Chavez, Councilor Lee Garcia, Councilor Michael Garcia, Councilor Jamie Cassutt, Councilor Renee Villarreal

Against: None

This item was approved with the amount of $414.230 with the $100,000 for CHART removed by the Finance Committee.

d. CONSIDERATION OF RESOLUTION NO. 2022-__ (Mayor Webber)
A Resolution Approving the Exchange and Transfer of Two Tracts of City-Owned Real Property to the State of New Mexico In Exchange for Six Tracts of State-Owned Real Property Located Within the City. (Terry Lease, Asset Development Manager, tjlease@santafenm.gov and Lee Logston, Midtown Asset Development Manager, lrlogston@santafenm.gov, 505-955-6914)

Committee Review:
Governing Body (Introduced): 10/26/2022
Quality of Life Committee: 11/2/2022
Finance Committee: 10/31/2022

Public Works and Utilities Committee: 11/7/2022
Governing Body: 11/9/2022

MOTION: Councilor Amanda Chavez moved, seconded by Councilor Lee Garcia, to approve the resolution as presented.

VOTE: The motion was on the following Roll Call vote:

For: Councilor Amanda Chavez, Councilor Lee Garcia, Councilor Michael Garcia, Councilor Jamie Cassutt, Councilor Renee Villarreal

Against: None

7. **MATTERS FROM STAFF**

8. **MATTERS FROM THE COMMITTEE**

9. **MATTERS FROM THE CHAIR**

10. **NEXT MEETING: December 07 2022**

11. **ADJOURN**

There being no further business before the Committee, the meeting adjourned at 5:50 pm.

Liaison

Chair

City of Santa Fe, New Mexico
Memorandum

DATE: **October 14, 2022**

TO: **Governing Body, December 14, 2022**
Quality of Life, December 7, 2022
Finance Committee, November 28, 2022

VIA: **John W Blair, City Manager**
Emily Oster, Finance Department Director
Fran Dunaway, Chief Procurement Officer
Rich Brown, Director, Community and Economic Development Richard Brown
Alexandra Ladd, Director, Office of Affordable Housing Alexandra Ladd

FROM: **Cody Minnich, Housing Grant Manager**

ITEM AND ISSUE:
Request for Approval of American Rescue Plan Act (ARPA) Recover Funds Subrecipient Contract in the Total Amount of $600,000 for Consuelo's Place Shelter under the first statutory category – to respond to the COVID-19 public health emergency or its negative economic impacts; New Mexico Coalition to End Homelessness; (Cody Minnich, cjminnich@santafenm.gov, (505) 955-6574)

BACKGROUND AND SUMMARY:
The City of Santa Fe is a recipient of a State and Local Fiscal Recovery Funds (SLFRF) award. The Office of Affordable Housing is administering $2,600,000 of the total award, of which $600,000 is being allocated toward the continued operation of Consuelo's Place Shelter, also known as the midtown emergency shelter.

Consuelo's Place Shelter (CPS) provides emergency shelter and services for those experiencing homelessness and for those at imminent risk of becoming homeless. CPS also provides quarantine services and housing for those who have recently tested positive with COVID-19, have had recent exposure to COVID-19 and/or are awaiting results. The latter service is offered to individuals and families who lack a safe space to quarantine during the period of infection.

CPS provides safe and stable emergency housing, intensive and high-quality case management, connects those facing a variety of housing related crises to appropriate resources and information and assists clients in securing and maintaining permanent housing after residency at CPS.

The ARPA funds will provide the funding required for CPS's operations and services, including emergency shelter stays, case management, formal and informal skill building for clients, quarantine services, general upkeep, and security services, to continue through June 30, 2023.

CONTRACT NUMBER:
The FY23 Munis contract number is 3203695.

PROJECT LEDGER:
The project ledger number is AFH222400B.

FUNDING SOURCE:
The funding source is:
Fund Name/Number: Community Development/Fund 240

Munis Org Name/Number: Housing Community Development Programs/2402750
Munis Object Name/Number: Grants and Services/510400

ACTION REQUESTED:
The Office of Affordable Housing respectfully requests your review and approval.

Item#_____
Munis Contract# _____

RECOVERY FUNDS SUBRECIPIENT
CONTRACT BETWEEN CITY OF SANTA FE AND NEW MEXICO COALITION TO END HOMELESSNESS
FOR CONSUELO'S PLACE SHELTER

THIS AGREEMENT is made and entered into by and between the City of Santa Fe, herein after referred to as the "City", and New Mexico Coalition to End Homelessness herein after referred to as the "Contractor."

RECITALS

WHEREAS, the City, as a recipient of a State and Local Fiscal Recovery Funds (SLFRF) award, has substantial discretion to use the award funds in the ways that best suit the needs of the City if such use fits into one of the following four statutory categories:

1. To respond to the COVID-19 public health emergency or its negative economic impacts;
2. To respond to workers performing essential work during the COVID-19 public health emergency by providing premium pay to eligible workers of the recipient that are performing such essential work, or by providing grants to eligible employers that have eligible workers who perform essential work;
3. For the provision of government services, to the extent of the reduction in revenue of such recipient due to the COVID–19 public health emergency, relative to revenues collected in the most recent full fiscal year of the recipient prior to the emergency; or
4. To make necessary investments in water, sewer, or broadband infrastructure;

WHEREAS this Contract falls within the first statutory category;

WHEREAS, recipients are responsible for ensuring that any procurement using SLFRF funds, or payments under procurement contracts using such funds, Coronavirus State and Local Fiscal Recovery Funds Compliance and Reporting Guidance are consistent with the procurement standards set forth in the Uniform Guidance at 2 CFR 200.317 through 2 CFR 200.327, as applicable;

WHEREAS, the Uniform Guidance establishes in 2 CFR 200.319 that all procurement transactions for property or services must be conducted in a manner providing full and open competition, consistent with standards outlined in 2 CFR 200.320, which allows for non-competitive procurements only in circumstances where at least one of the conditions below is true: the item is below the micro-purchase threshold of $50,000; the item is only available from a single source; the public exigency or emergency will not permit a delay from publicizing a competitive solicitation; or after solicitation of a number of sources, competition is determined inadequate;

WHEREAS, Subrecipients under the SLFRF program are entities that receive a subaward from a recipient to carry out the purposes (program or project) of the SLFRF award on behalf of the recipient; and

WHEREAS New Mexico Coalition to End Homelessness understands that this contract represents a subaward of SLFRF funds, agrees to maintain records to satisfy all compliance requirements for use of SLFRF, and agrees to all reporting requirements for expenditures of SLFRF funds.

IT IS MUTUALLY AGREED BETWEEN THE PARTIES:

1. **Definitions**

A. "Products and Services Schedule" refers to the complete list of products and services offered under this Agreement and the price for each. Product and service descriptions may be amended with the prior approval of the Agreement Administrator. New products and services shall not be added to the Products and Services Schedule.

B. "Business Hours" means 8:00 a.m. to 5:00 p.m. Mountain Time.

C. "Subrecipient" means an entity, usually but not limited to non–Federal entities, that receives a subaward from a pass-through entity to carry out part of a Federal award; but does not include an individual that is a beneficiary of such award. 2 C.F.R. § 200.1

D. "You" and "your" refers to **New Mexico Coalition to End Homelessness**. "We," "us" or "our" refers to the City and whose accounts are created under this Agreement.

2. **Scope of Work**

The Contractor shall perform the work as follows:

A. Provide staffing for "Consuelo's Place Shelter" documented as follows:
   a. The staff on the payroll must be directly involved in the daily operation of the funded program/activities;
   b. Time sheets are required and the number of hours in the payroll must match the time sheets.
   c. Prior to commencement of funded activity, Contractor will provide to the City a staffing plan and time commitments (by percentage of an FTE) to be allocated to the funded activities, if applicable.

B. Provide services including emergency shelter stays, case management, formal and informal skill building for clients, quarantine services, and security services.

C. Serve a minimum of two hundred forty (240) individuals who meet federal definitions of homelessness or other standards of housing instability.

D. Participate in the NM Coordinated Entry System (CES), managed by the NM Coalition to End Homelessness (NMCEH), as follows:
   a. Ensure that intake staff is trained in completing an assessment identified by the New Mexico Coalition to End Homelessness (NMCEH) CES.
   b. Complete the Assessment with all persons experiencing homelessness who

present to the agency for housing services and provide the completed assessments to NM CES by either sending them to NMCEH or entering them into HMIS (depending on Contractor's level of HMIS and CES Access).

c. Select from the NM CES prioritized list to fill openings when appropriate.

d. Participate in case conferencing when intakes result in new clients who end up on the priority list so that the process moves beyond status updates to focus on action-oriented housing outcomes.

E. Report to the City on a quarterly basis the use of funds, program outcomes achieved, and specifying eligibility of people served.

3. **Compensation**

Compensation Schedule. The City shall pay to the Contractor based upon fixed prices for each Deliverable, per the schedule outlined in Exhibit A, less retainage, if any, as identified in paragraph D of this Clause.

A. Payment. The total compensation under this Agreement shall not exceed $600,000. This amount is a maximum and not a guarantee that the work assigned to be performed by Contractor under this Agreement shall equal the amount stated herein. The Parties do not intend for the Contractor to continue to provide Services without compensation when the total compensation amount is reached. Contractor is responsible for notifying the City when the Services provided under this Agreement reach the total compensation amount. In no event will the Contractor be paid for Services provided in excess of the total compensation amount without this Agreement being amended in writing prior to services, in excess of the total compensation amount being provided.

B. Compensation will be paid under this agreement only after all funds provided for in the "Agreement Between the City of Santa Fe, New Mexico and New Mexico Coalition to End Homelessness for Consuelo's Place," also known as CDBG funds, have been used in order to avoid Duplication of Benefits.

C. Payment shall be made upon the receipt and Acceptance of a detailed, certified Payment Invoice. Payment will be made to the Contractor's designated mailing address. In accordance with Section 13-1-158 NMSA 1978, payment shall be tendered to the Contractor within thirty (30) days of the date of written certification of Acceptance. All Payment Invoices MUST BE received by the City no later than fifteen (15) days after the termination of this Agreement. Payment Invoices received after such date WILL NOT BE PAID.

D. Retainage. The Parties agree there is no retainage.

E. Performance Bond. The Parties agree there is no Performance Bond.

F. The contractor may use SLFRF funds to cover eligible costs incurred during the period that begins on March 3, 2021 and ends on December 31, 2024, if the award funds for the

obligations incurred by December 31, 2024 are expended by December 31, 2026. Costs for projects incurred by the subrecipient prior to March 3, 2021 are not eligible, as provided for in Treasury's final rule. Any funds not obligated or expended for eligible uses by the timelines above must be returned to Treasury, including any unobligated or unexpended funds that have been provided to subrecipients and contractors as part of the award closeout process pursuant to 2 C.F.R. 200.344(d).

4. **Term**

THIS AGREEMENT SHALL NOT BECOME EFFECTIVE UNTIL APPROVED IN WRITING BY THE CITY. This Agreement shall begin on date approved by the City and end on June 30, 2023. In no event will the term exceed the duration allowed by statute, NMSA 1978, § 13-1-150.

5. **Default and Force Majeure**

The City reserves the right to cancel all or any part of any orders placed under this contract without cost to the City, if the Contractor fails to meet the provisions of this contract and, except as otherwise provided herein, to hold the Contractor liable for any excess cost occasioned by the City due to the Contractor's default. The Contractor shall not be liable for any excess costs if failure to perform the order arises out of causes beyond the control and without the fault or negligence of the Contractor; such causes include, but are not restricted to, acts of God or the public enemy, acts of the State or Federal Government, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, unusually severe weather and defaults of sub-contractors due to any of the above, unless the City shall determine that the supplies or services to be furnished by the sub-contractor were obtainable from other sources in sufficient time to permit the Contractor to meet the required delivery scheduled. The rights and remedies of the City provided in this paragraph shall not be exclusive and are in addition to any other rights now being provided by law or under this contract.

6. **Termination**

A. Grounds. The City may terminate this Agreement for convenience or cause. The Contractor may only terminate this Agreement based upon the City's uncured, material breach of this Agreement.

B. Notice; City Opportunity to Cure.

1) Except as otherwise provided in Paragraphs 7.A and 17, the City shall give Contractor written notice of termination at least thirty (30) days prior to the intended date of termination.

2) Contractor shall give City written notice of termination at least thirty (30) days prior to the intended date of termination, which notice shall (i) identify all the City's material breaches of this Agreement upon which the termination is based and (ii) state what the City must do to cure such material breaches. Contractor's notice of termination shall only be effective (i) if the City does not cure all material breaches within the thirty (30) day notice period or (ii) in the case of material breaches that cannot be cured within thirty (30) days, the City does

not, within the thirty (30) day notice period, notify the Contractor of its intent to cure and begin with due diligence to cure the material breach.

3) Notwithstanding the foregoing, this Agreement may be terminated immediately upon written notice to the Contractor (i) if the Contractor becomes unable to perform the services contracted for, as determined by the City; (ii) if, during the term of this Agreement, the Contractor is suspended or debarred by the City; or (iii) the Agreement is terminated pursuant to Paragraph 17, "Appropriations", of this Agreement.

C. Liability. Except as otherwise expressly allowed or provided under this Agreement, the City's sole liability upon termination shall be to pay for acceptable work performed prior to the Contractor's receipt or issuance of a notice of termination; provided, however, that a notice of termination shall not nullify or otherwise affect either party's liability for pre-termination defaults under or breaches of this Agreement. The Contractor shall submit an invoice for such work within thirty (30) days of receiving or sending the notice of termination. *THIS PROVISION IS NOT EXCLUSIVE AND DOES NOT WAIVE THE CITY'S OTHER LEGAL RIGHTS AND REMEDIES CAUSED BY THE CONTRACTOR'S DEFAULT/BREACH OF THIS AGREEMENT.*

7. Amendment

A. This Agreement shall not be altered, changed or amended except by instrument in writing executed by the parties hereto and all other required signatories.

B. If the City proposes an amendment to the Agreement to unilaterally reduce funding due to budget or other considerations, the Contractor shall, within thirty (30) days of receipt of the proposed Amendment, have the option to terminate the Agreement, pursuant to the termination provisions as set forth in Paragraph 7 herein, or to agree to the reduced funding.

8. Status of Contractor

The Contractor, and Contractor's agents and employees, are independent Contractors for the City and are not employees of the City. The Contractor, and Contractor's agents and employees, shall not accrue leave, retirement, insurance, bonding, use of City vehicles, or any other benefits afforded to employees of the City as a result of this Agreement. The Contractor acknowledges that all sums received hereunder are personally reportable by the Contractor for income tax purposes, including without limitation, self-employment tax and business income tax. The Contractor agrees not to purport to bind the City unless the Contractor has written authority to do so, and then only within the strict limits of that authority.

9. Assignment

The Contractor shall not assign or transfer any interest in this Agreement or assign any claims for money due or to become due under this Agreement without the prior written approval of the City.

10. Subcontracting

The Contractor shall not subcontract any portion of the services to be performed under

this Agreement without the prior written approval of the City. No such subcontract shall relieve the primary Contractor from its obligations and liabilities under this Agreement, nor shall any subcontract obligate direct payment from the City.

11. **Non-Collusion**

In signing this Agreement, the Contractor/Contractor certifies the Contractor/Contractor has not, either directly or indirectly, entered into action in restraint of free competitive bidding in connection with this offer submitted to the City.

12. **Inspection of Plant**

The City may inspect, at any reasonable time during Contractor's regular business hours and upon prior written notice, the Contractor's plant or place of business, or any subcontractor's plant or place of business, which is related to the performance of this contract.

13. **Commercial Warranty**

The Contractor agrees that the tangible personal property or services furnished under this Agreement shall be covered by the most favorable commercial warranties the Contractor gives to any customer for such tangible personal property or services, and that the rights and remedies provided herein shall extend to the City and are in addition to and do not limit any rights afforded to the City by any other clause of this order. Contractor agrees not to disclaim warranties of fitness for a particular purpose or merchantability.

14. **Condition of Proposed Items**

Where tangible personal property is a part of this Agreement, all proposed items are to be NEW and of most current production, unless otherwise specified.

15. **Records and Audit**

During the term of this Agreement and for five years thereafter, the Contractor shall maintain detailed records pertaining to the services rendered and products delivered. These records shall be subject to inspection by the City, the State Auditor and other appropriate state and federal authorities. The City shall have the right to audit billings both before and after payment. Payment under this Agreement shall not foreclose the right of the City to recover excessive or illegal payments.

16. **Appropriations**

The terms of this Agreement, and any orders placed under it, are contingent upon sufficient appropriations and authorization being made by the City Council for the performance of this Agreement. If sufficient appropriations and authorization are not made by the legislature, this Agreement, and any orders placed under it, shall terminate upon written notice being given by the City to the Contractor. The City's decision as to whether sufficient appropriations are

available shall be accepted by the Contractor and shall be final. If the City proposes an amendment to the Agreement to unilaterally reduce funding, the Contractor shall have the option to terminate the Agreement or to agree to the reduced funding, within thirty (30) days of receipt of the proposed amendment.

17. **Release**

The Contractor, upon final payment of the amount due under this Agreement, releases the City, its officers and employees, from all liabilities, claims and obligations whatsoever arising from or under this Agreement. The Contractor agrees not to purport to bind the City, unless the Contractor has express written authority to do so, and then only within the strict limits of that authority.

18. **Confidentiality**

Any confidential information provided to or developed by the Contractor in the performance of this Agreement shall be kept confidential and shall not be made available to any individual or organization by the Contractor without prior written approval by the City.

19. **Conflict of Interest**

A. The Contractor represents and warrants that it presently has no interest and, during the term of this Agreement, shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance or services required under the Agreement. The Contractor shall comply with any applicable provisions of the New Mexico Governmental Conduct Act and the New Mexico Financial Disclosures Act.

B. The Contractor further represents and warrants that it has complied with, and, during the term of this Agreement, will continue to comply with, and that this Agreement complies with all applicable provisions of the Governmental Conduct Act, Chapter 10, Article 16 NMSA 1978.

C. Contractor's representations and warranties in Paragraphs A and B of this Paragraph are material representations of fact upon which the City relied when this Agreement was entered into by the parties. Contractor shall provide immediate written notice to the City if, at any time during the term of this Agreement, Contractor learns that Contractor's representations and warranties in Paragraphs A and B of this Paragraph 20 were erroneous on the effective date of this Agreement or have become erroneous by reason of new or changed circumstances. If it is later determined that Contractor's representations and warranties in Paragraphs A and B of this Paragraph 20 were erroneous on the effective date of this Agreement or have become erroneous by reason of new or changed circumstances, in addition to other remedies available to the City and notwithstanding anything in the Agreement to the contrary, the City may immediately terminate the Agreement.

D. All terms defined in the Governmental Conduct Act have the same meaning in this section.

20. **Approval of Contractor Representative(s)**

The City reserves the right to require a change in Contractor representative(s) if the assigned representative(s) are not, in the opinion of the City, adequately serving the needs of the City.

21. **Scope of Agreement; Merger**

This Agreement incorporates all the agreements, covenants, and understandings between the parties hereto concerning the subject matter hereof, and all such covenants, agreements and understandings have been merged into this written Agreement. No prior agreements or understandings, verbal or otherwise, of the parties or their agents shall be valid or enforceable unless embodied in this Agreement.

22. **Notice**

The Procurement Code, Sections 13-1-28 through 13-1-199 NMSA 1978, imposes civil and criminal penalties for its violation. In addition, the New Mexico criminal statutes impose felony penalties for bribes, gratuities and kickbacks.

23. **Equal Opportunity Compliance**

The Contractor agrees to abide by all federal and state laws, and local Ordinances, pertaining to equal employment opportunity. In accordance with all such laws, rules, and regulations, the Contractor agrees to assure that no person in the United States shall on the grounds of race, religion, color, national origin, ancestry, sex, age, physical or mental handicap, or serious medical condition, spousal affiliation, sexual orientation or gender identity, be excluded from employment with or participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity performed under this Agreement. If Contractor is found not to be in compliance with these requirements during the life of this Agreement, Contractor agrees to take appropriate steps to correct these deficiencies.

24. **Indemnification**

The Contractor shall hold the City and its employees harmless and shall indemnify the City and its employees against any and all claims, suits, actions, liabilities and costs of any kind, including attorney's fees for personal injury or damage to property arising from the acts or omissions of the Contractor, its agents, officers, employees or subcontractors. The Contractor shall not be liable for any injury or damage as a result of any negligent act or omission committed by the City, its officers or employees.

25. **New Mexico Tort Claims Act**

Any liability incurred by the City of Santa Fe in connection with this Agreement is subject to the immunities and limitations of the New Mexico Tort Claims Act, Section 41-4-1, et. seq.

NMSA 1978, as amended. The City and its "public employees" as defined in the New Mexico Tort Claims Act, do not waive sovereign immunity, do not waive any defense and do not waive any limitation of liability pursuant to law. No provision in this Agreement modifies or waives any provision of the New Mexico Tort Claims Act.

26. **Applicable Law**

The laws of the State of New Mexico shall govern this Agreement, without giving effect to its choice of law provisions. Venue shall be proper only in a New Mexico court of competent jurisdiction in accordance with NMSA 1978, § 38-3-2. By execution of this Agreement, Contractor acknowledges and agrees to the jurisdiction of the courts of the State of New Mexico over any and all lawsuits arising under or out of any term of this Agreement.

27. **Limitation of Liability**

The Contractor's liability to the City, for any cause whatsoever shall be limited to the purchase price paid to the Contractor for the products and services that are the subject of the City's, claim. The foregoing limitation does not apply to paragraph 25 of this Agreement or to damages resulting from personal injury caused by the Contractor's negligence.

28. **Incorporation by Reference and Precedence**

If this Agreement has been procured pursuant to a request for proposals, this Agreement is derived from (1) the request for proposal, (including any written clarifications to the request for proposals and any City response to questions); (2) the Contractor's best and final offer; and (3) the Contractor's response to the request for proposals.

In the event of a dispute under this Agreement, applicable documents will be referred to for the purpose of clarification or for additional detail in the following order of precedence: (1) amendments to the Agreement in reverse chronological order; (2) the Agreement, including the scope of work and all terms and conditions thereof; (3) the request for proposals, including attachments thereto and written responses to questions and written clarifications; (4) the Contractor's best and final offer if such has been made and accepted by the City; and (5) the Contractor's response to the request for proposals.

29. **Workers' Compensation**

The Contractor agrees to comply with state laws and rules applicable to workers' compensation benefits for its employees. If the Contractor fails to comply with the Workers' Compensation Act and applicable rules when required to do so, this Agreement may be terminated by the City.

30. **Inspection**

If this contract is for the purchase of tangible personal property (goods), final inspection and acceptance shall be made at Destination. Tangible personal property rejected at Destination

for non-conformance to specifications shall be removed at Contractor's risk and expense promptly after notice of rejection and shall not be allowable as billable items for payment.

31. **Inspection of Services**

If this contract is for the purchase of services, the following terms shall apply.

A. Services, as used in this Article, include services performed, workmanship, and material furnished or utilized in the performance of services.

B. The Contractor shall provide and maintain an inspection system acceptable to the City covering the services under this Agreement. Complete records of all inspection work performed by the Contractor shall be maintained and made available to the City and for as long thereafter as the Agreement requires. The City has the right to inspect and test all services contemplated under this Agreement to the extent practicable at all times and places during the term of the Agreement. The City shall perform inspections and tests in a manner that will not unduly delay or interfere with Contractor's performance.

C. If the City performs inspections or tests on the premises of the Contractor or a subcontractor, the Contractor shall furnish, and shall require subcontractors to furnish, at no increase in contract price, all reasonable facilities and assistance for the safe and convenient performance of such inspections or tests.

D. If any part of the services do not conform with the requirements of this Agreement, the City may require the Contractor to re-perform the services in conformity with the requirements of this Agreement at no increase in contract amount. When the defects in services cannot be corrected by re-performance, the City may:

(1) require the Contractor to take necessary action(s) to ensure that future performance conforms to the requirements of this Agreement; and

(2) reduce the contract price to reflect the reduced value of the services performed.

E. If the Contractor fails to promptly re-perform the services or to take the necessary action(s) to ensure future performance in conformity with the requirements of this Agreement, the City may:

(1) by contract or otherwise, perform the services and charge to the Contractor any cost incurred by the City that is directly related to the performance of such service; or

(2) terminate the contract for default.

32. **Insurance**

If the services contemplated under this Agreement will be performed on or in City facilities or property, Contractor shall maintain in force during the entire term of this Agreement, the following insurance coverage(s), naming the City as additional insured.

A. Commercial General Liability insurance shall be written on an occurrence basis and be a broad as ISO Form CG 00 01 with limits not less than $2,000,000 per occurrence and $2,000,000 in the aggregate for claims against bodily injury, personal and advertising injury, and property damage. Said policy shall include broad form Contractual Liability coverage and be

endorsed to name the City of Santa Fe their officials, officers, employees, and agents as additional insureds.

B. Broader Coverage and Limits. The insurance requirements under this Agreement shall be the greater of (1) the minimum coverage and limits specified in this Agreement, or (2) the broader coverage and maximum limits of coverage of any insurance policy or proceeds available to the Named Insured. It is agreed that these insurance requirements shall not in any way act to reduce coverage that is broader or that includes higher limits than the minimums required herein. No representation is made that the minimum insurance requirements of this Agreement are sufficient to cover the obligations of Contractor hereunder.

C. Contractor shall maintain the above insurance for the term of this Agreement and name the City as an additional insured and provide for 30 days cancellation notice on any Certificate of Insurance form furnished by Contractor. Such certificate shall also specifically state the coverage provided under the policy is primary over any other valid and collectible insurance and provide a waiver of subrogation.

33. **Impracticality of Performance**

A party shall be excused from performance under this Agreement for any period that the party is prevented from performing as a result of an act of God, strike, war, civil disturbance, epidemic, or court order, provided that the party has prudently and promptly acted to take any and all steps that are within the party's control to ensure performance. Subject to this provision, such non-performance shall not be deemed a default or a ground for termination.

34. **Invalid Term or Condition**

If any term or condition of this Agreement shall be held invalid or unenforceable, the remainder of this Agreement shall not be affected and shall be valid and enforceable.

35. **Enforcement of Agreement**

A party's failure to require strict performance of any provision of this Agreement shall not waive or diminish that party's right thereafter to demand strict compliance with that or any other provision. No waiver by a party of any of its rights under this Agreement shall be effective unless express and in writing, and no effective waiver by a party of any of its rights shall be effective to waive any other rights.

36. **Patent, Copyright and Trade Secret Indemnification**

A. The Contractor shall defend, at its own expense, the City against any claim that any product or service provided under this Agreement infringes any patent, copyright to trademark in the United States or Puerto Rico, and shall pay all costs, damages and attorneys' fees that a court finally awards as a result of any such claim. In addition, if any third party obtains a judgment against the City based upon Contractor's trade secret infringement relating to any product or services provided under this Agreement, the Contractor agrees to reimburse the

City for all costs, attorneys' fees and amount of the judgment. To qualify for such defense and or payment, the City shall:

1) give the Contractor prompt written notice within 48 hours of any claim;
2) allow the Contractor to control the defense of settlement of the claim; and
3) cooperate with the Contractor in a reasonable way to facilitate the defense or settlement of the claim.

B. If any product or service becomes, or in the Contractor's opinion is likely to become the subject of a claim of infringement, the Contractor shall at its option and expense:

1) provide the City the right to continue using the product or service and fully indemnify the City against all claims that may arise out of the City's use of the product or service;

2) replace or modify the product or service so that it becomes non-infringing; or,

3) accept the return of the product or service and refund an amount equal to the value of the returned product or service, less the unpaid portion of the purchase price and any other amounts, which are due to the Contractor. The Contractor's obligation will be void as to any product or service modified by the City to the extent such modification is the cause of the claim.

37. **Survival**

The Agreement paragraphs titled "Patent, Copyright, Trademark, and Trade Secret Indemnification; Indemnification; and Limit of Liability" shall survive the expiration of this Agreement. Software licenses, leases, maintenance and any other unexpired Agreements that were entered into under the terms and conditions of this Agreement shall survive this Agreement.

38. **Disclosure Regarding Responsibility**

A. Any prospective Contractor and any of its Principals who enter into a contract greater than sixty thousand dollars ($60,000.00) with any City for professional services, tangible personal property, services or construction agrees to disclose whether the Contractor, or any principal of the Contractor's company is presently debarred, suspended, proposed for debarment, or declared ineligible for award of contract by any federal entity, state agency or local public body.

B. Principal, for the purpose of this disclosure, means an officer, director, owner, partner, or a person having primary management or supervisory responsibilities within a business entity or related entities.

C. The Contractor shall provide immediate written notice to the City if, at any time during the term of this Agreement, the Contractor learns that the Contractor's disclosure was at any time erroneous or became erroneous by reason of changed circumstances.

D. A disclosure that any of the items in this requirement exist will not necessarily result in termination of this Agreement. However, the disclosure will be considered in the

determination of the Contractor's responsibility and ability to perform under this Agreement. Failure of the Contractor to furnish a disclosure or provide additional information as requested will be grounds for immediate termination of this Agreement pursuant to the conditions set forth in Paragraph 7 of this Agreement.

E. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render, in good faith, the disclosure required by this document. The knowledge and information of a Contractor is not required to exceed that which is the normally possessed by a prudent person in the ordinary course of business dealings.

F. The disclosure requirement provided is a material representation of fact upon which reliance was placed when making an award and is a continuing material representation of the facts during the term of this Agreement. If during the performance of the contract, the Contractor is indicted for or otherwise criminally or civilly charged by any government entity (federal, state or local) with commission of any offenses named in this document the Contractor must provide immediate written notice to the City. If it is later determined that the Contractor knowingly rendered an erroneous disclosure, in addition to other remedies available to the Government, the City may terminate the involved contract for cause. Still further the City may suspend or debar the Contractor from eligibility for future solicitations until such time as the matter is resolved to the satisfaction of the City.

39. **Suspension, Delay or Interruption of Work**

The City may, without cause, order the Contractor, in writing, to suspend, delay or interrupt the work in whole or in part for such period as the City may determine. The contract sum and contract time shall be adjusted for increases in cost and/or time associated with Contractor's compliance therewith. Upon receipt of such notice, Contractor shall leave the jobsite and any equipment in a safe condition prior to departing. Contractor must assert rights to additional compensation within thirty (30) days after suspension of work is lifted and return to work is authorized. Any compensation requested for which entitlement is granted and the contract sum adjusted, shall have profit included (for work completed) and for cost only (not profit) for Contractor costs incurred directly tied to the suspension itself and not otherwise covered by Contract remedy. Any change in Total Compensation must be reflected in an Amendment executed pursuant to Section 8 of this Agreement.

40. **Notification**

Either party may give written notice to the other party in accordance with the terms of this Paragraph. Any written notice required or permitted to be given hereunder shall be deemed to have been given on the date of delivery if delivered by personal service or hand delivery or three (3) business days after being mailed.

To the City:
City of Santa Fe
Office of Affordable Housing
PO Box 909
Santa Fe, New Mexico 87504-0909

To the Contractor:

New Mexico Coalition to End Homelessness
440 Cerrillos Road, Ste 4
Santa Fe, NM 87501

Either party may change its representative or address above by written notice to the other in accordance with the terms of this Paragraph. The carrier for mail delivery and notices shall be the agent of the sender.

To the Contractor:

New Mexico Coalition to End Homelessness
440 Cerrillos Road, Ste 4
Santa Fe, NM 87501

41. **Succession**

This Agreement shall extend to and be binding upon the successors and assigns of the parties.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the date of the signature by the required approval authorities below.

CITY OF SANTA FE:

_____
ALAN WEBBER, MAYOR

DATE:_____

CONTRACTOR:

_____
HANK HUGHES
EXECUTIVE DIRECTOR

DATE:_____

CRS# 02-937190-00-2

Registration # 225192

ATTEST:

_____
KRISTINE BUSTOS MIHELCIC, CITY CLERK

CITY ATTORNEY'S OFFICE:

Marcos Martinez
Marcos Martinez (Sep 19, 2022 08:12 MDT)

SENIOR ASSISTANT CITY ATTORNEY

APPROVED FOR FINANCES:

EMILY OSTER, FINANCE DIRECTOR

2402750.510400 AH
AH
Org.Name/Org.#

City of Santa Fe

Real Estate Summary of Contracts, Agreements, Amendments & Leases

Section to be completed by department

1. Munis Contract # **3203695**

Contractor: **NM Coalition To End Homelessness**

Description: **ARPA funds will provide the funding required for CPS's operations and services, including emergency shelter stays, case management, formal and informal skill building for clients, quarantine, general upkeep and security services**

Contract ☐ Agreement ☉ Lease / Rent ☐ Amendment ☐

Term Start Date: **Upon Approval** Term End Date: **06/30/2023**

☐ Approved by Council Date: _____

Contract / Lease:

Amendment # _____ to the Original Contract / Lease # _____

Increase/(Decrease) Amount $ _____

Extend Termination Date to: _____

☐ Approved by Council Date: _____

Amendment is for:

2. **HISTORY** of Contract, Amendments & Lease / Rent - **Please Elaborate** (option: attach spreadsheet if multiple amendments)
Original Contract: $600,000 (Sole Source)

3. **Procurement History:** _____

Purchasing Officer Review: Oct 31, 2022 Date:

Comment & Exceptions: SS posted 30-days w/out protest

4. **Funding Source:** **240** **Org / Object:** **24002750.510400**

Andy Hopkins (Oct 28, 2022 15:52 MDT) Oct 28, 2022

Budget Officer Approval: Date:

Comment & Exceptions: _____

Staff Contact who completed this form: **Roberta Catanach** Phone # **505-955-6421**

Email: **rlcatanach@santafenm.gov**

To be recorded by City Clerk:

Clerk # _____

Date of Execution: _____

CITY OF SANTA FE PROCUREMENT CHECKLIST

Contractor Name: New Mexico Coalition To End Homelessness

Procurement Title: Sole Source

Procurement Method: State Price Agreement ☐ Cooperative ☐ Sole Source ☐ Other ☐

Exempt ☐ Request For Proposal (RFP) ☐ Invitation To Bid (ITB) ☐ Contract under 60K ☐ Contract over 60K ☐

Department Requesting OAH Staff Name Roberta Catanach

Procurement Requirements:

A procurement file shall be maintained for all contracts, regardless of the method of procurement. The procurement file shall contain the basis on which the award is made, all submitted bids, all evaluation materials, score sheets, quotations and all other documentation related to or prepared in conjunction with evaluation, negotiation, and the award process. The procurement shall contain a written determination from the Requesting Department, signed by the purchasing officer, setting forth the reasoning for the contract award decision before submitting to the Committees.

REQUIRED DOCUMENTS FOR APPROVAL BY PURCHASING*

YES	N/A	
☑	☐	Approved Procurement Checklist (by Purchasing)
☑	☐	Memo addressed to City Manager (under 60K) Committees/City Council (over 60K)
☐	☑	State Price Agreement
☐	☑	RFP
☐	☑	Evaluation Committee Report
☐	☑	ITB
☐	☑	Bib Tab
☐	☑	Quotes (3 valid current quotes)
☐	☑	Cooperative Agreement
☑	☐	Sole Source Request and Determination Form
☐	☑	Contractors Exempt Letter
☐	☑	Purchasing Officers approval for exempt procurement
☐	☑	BAR
☐	☐	FIR
☑	☐	Executed Contract, Agreement or Amendment
☑	☐	Current Business Registration and CRS numbers on contract or agreement
☑	☐	Summary of Contracts and Agreements form
☑	☐	Certificate of Insurance
☑	☐	All documentation presented to Committees
☐	☑	Other:

Roberta Catanach	Contract Administrator	03/16/2022
Department Rep Printed Name (attesting that all information included)	Title	Date
	Contracts Supervisor	Oct 31, 2022
Purchasing Officer (attesting that all information is reviewed)	Title	Date

Include all other substantive documents and records of communication that pertain to the procurement and contract.

City of Santa Fe

Treasury Department
200 Lincoln Ave.
Santa Fe, New Mexico 87504-0909
505-955-6551

BUSINESS REGISTRATION

Business Name: NM COALITION TO END HOMELESS
DBA: NM COALITION TO END HOMELESS

Business Location: 440 CERRILLOS RD
SANTA FE, NM 87501

CRS Number: 02937190002

Owner: NM COALITION TO END HOMELESS

License Number: 225192

License Type: Business License - Renewable

Issued Date: March 29, 2022

Classification: Business Registration - Standard

Expiration Date: March 29, 2023

Fees Paid: $35.00

Description: NON-PROFIT

NM COALITION TO END HOMELESS
PO BOX 865
SANTA FE, NM 87504

THIS IS NOT A CONSTRUCTION PERMIT OR SIGN PERMIT. APPROPRIATE PERMITS MUST BE OBTAINED FROM THE CITY OF SANTA FE BUILDING PERMIT DIVISION PRIOR TO COMMENCEMENT OF ANY CONSTRUCTION OR THE INSTALLATION OF ANY EXTERIOR SIGN.

THIS REGISTRATION/LICENSE IS NOT TRANSFERRABLE TO OTHER BUSINESSES OR PREMISES.

TO BE POSTED IN A CONSPICUOUS PLACE

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/18/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Daniels Insurance, Inc.-Santa Fe 805 St Michaels Drive Santa Fe NM 87505	CONTACT NAME: Ed Risley PHONE (A/C, No, Ext): (505) 982-4302 FAX (A/C, No): (505) 989-9186 E-MAIL ADDRESS: erisley@danielsinsuranceinc.com
	INSURER(S) AFFORDING COVERAGE — NAIC #
	INSURER A : Philadelphia Indemnity Insuran — 18058
INSURED (505) 660-8845 Consuelo's Place PO Box 865 Santa Fe NM 87504	INSURER B : New Mexico Assurance Company — 13673 INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** Cert ID 34938 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$ 1,000,000
	[ ] CLAIMS-MADE [X] OCCUR	Y		PHPK2435101	08/15/2022	08/15/2023	DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
							MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 2,000,000
	X POLICY [ ] PRO-JECT [ ] LOC						PRODUCTS - COMP/OP AGG	$ 2,000,000
	[ ] OTHER:							$
A	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	[ ] ANY AUTO			PHPK2435101	08/15/2022	08/15/2023	BODILY INJURY (Per person)	$
	[ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	X HIRED AUTOS ONLY X NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	[ ] UMBRELLA LIAB [ ] OCCUR						EACH OCCURRENCE	$
	[ ] EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$
	[ ] DED [ ] RETENTION $							$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N			0101816.103	08/15/2022	08/15/2023	X PER STATUTE [ ] OTH-ER	
	ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] N / A (Mandatory in NH)						E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000
A	Professional			PHPK2435101	08/15/2022	08/15/2023	Ea Occurrence	$ 1,000,000
A	Professional			PHPK2435101	08/15/2022	08/15/2023	Aggregate	$ 2,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

General liability policies contain a Blanket Additional Insured provision that establishes the scope of Additional Insured coverage granted to the Certificate Holder. Where permitted by state law, and per a Blanket Waiver of Subrogation Endorsement, the Insurer waives its right to subrogate against the Certificate Holder by reason of payments made under the General liability policies but only under the circumstances stated in the policies.Regarding "Consuelo's Place Shelter to provide non-congregate shelter to people experiencing homelessness or who need to quarantine due to COVID-19"

CERTIFICATE HOLDER

City of Santa Fe

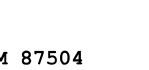
PO Box 909

Santa Fe NM 87504

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE



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City of Santa Fe, New Mexico

SOLE SOURCE REQUEST AND DETERMINATION FORM

This sole source request form must be submitted to the City of Santa, Purchasing Division for authorization, determination and processing by the Chief Procurement Officer (CPO).

Please ensure to complete this form in its entirety - ***(*) must be completed.***

***Date:** 9/7/2022

***Prepared By:** Cody Minnich ***Title:** Housing Grant Manager, Office of Affordable Housing

***Vendor Name:** New Mexico Coalition to End Homelessness (Fiscal Agent for Consuelo's Place Shelter)

***Address:** 1600 St Michaels Dr, Bldg 7

***City:** Santa Fe ***State:** NM ***Zip Code:** 87505

***Description of Goods/Service to be procured:**

***Estimated Cost:** $600,000 **Term of Contract:** **One (1) to Four (4) year from award)** 1 year

award)

***Sole Source Request Justification Questions 1-3.**

1. **Explain the purpose/need of purchase. Ensure to include a thorough scope of work for the services, construction or items of tangible personal property (if this is an amendment request to an existing contract, attach current contract).**

Consuelo's Place Shelter (CPS) provides emergency shelter and services for those experiencing homelessness and for those at imminent risk of becoming homeless. CPS also provides quarantine services and housing for those who have recently tested positive with COVID-19, have had recent exposure to COVID-19 and/or are awaiting results. The latter service is offered to individuals and families who lack a safe space to quarantine during the period of infection.

CPS provides safe and stable emergency housing, intensive and high-quality case management, connects those facing a variety of housing related crises to appropriate resources and information and assists clients in securing and maintaining permanent housing after residency at CPS.

The American Rescue Plan Act (ARPA) funds subject to this Sole Source will provide the funding required for CPS's operations and services, including emergency shelter stays, case management, formal and informal skill building for clients, quarantine services, general upkeep, and security services, to continue through June 30, 2023.

2. Provide a detailed explanation of the criteria developed and specified by the department as necessary to perform and/or fulfill the contract.

X	**The contractor has affirmed sole source for the services, construction or items of tangible personal property *(Attach memo from vendor)*. Provide documentation of due diligence for other possible vendors/contractors to provide the requested services/goods proved unsuccessful; or**
	Other: explanation of the reasons, qualifications, proprietary rights or unique capabilities (*unique and how this uniqueness is substantially related to the intended purpose of the contract)* of the prospective contractor that makes the prospective contractor *the one source* capable of providing the required professional service, service, construction or item(s) of tangible personal property. (Please do not state the source is the "best" source or the "least costly" source. Those factors do not justify a "sole source.") U*nique and how this uniqueness is substantially related to the intended purpose of the contract*.

In FY 2021-2022 CPS served 240 individuals with shelter services and has a total number of 52 beds reserved for this purpose. Of these, CPS served 20 families with children who were facing homelessness. CPS served an additional 74 individuals with quarantine services with a total number of 24 beds reserved for this purpose.

Funding for the continuance of Consuelo's Place Shelter will maintain the increased availability of short-term shelter services for LMI residents in Santa Fe that it has brought about since its opening in August 2020. Access to short-term shelter services will allow clients safe and stable short-term housing while they apply for vouchers, seek permanent housing situations and stabilize their housing situations. As long as the COVID-19 pandemic continues, the shelter will also offer a select number of rooms to COVID positive clients so that they may self-isolate, quarantine, and prevent spread of the virus while they are symptomatic.

Case managers and staff at Consuelo's Place Shelter will aid clients in seeking jobs and needed documentation to obtain housing, find supportive resources and programs when needed and will network with case managers at other housing agencies in the city to ensure cross-communication in assisting clients with their various needs.

3. Explain why other similar professional services, services, construction or item(s) of tangible personal property *cannot* meet the intended purpose of the contract.

Consuelo's Place Shelter opened to address a need in the Santa Fe community for safe and stable short-term housing for those in housing crises. With a shortage of over 7,343 rental units in Santa Fe (cited from the 2021 Santa Fe Housing Report) in the past year, access and ability to seek permanent housing in Santa Fe for our most vulnerable and low-income residents is often difficult and met with a variety of road blocks. With affordable housing and rental unit shortages, the need for short-term, non-congregate housing while clients apply for and seek out stable permanent housing becomes all the more important in our community.

Access to Consuelo's Place's private rooms for individuals and families not only allows for stability while households seek and obtain permanent housing but also creates safety during the pandemic and provides clients with a shelter service that offers non-congregate services; mitigating the spread of infectious diseases for its residents.

Consuelo's Place Shelter is the only COVID-19 quarantine shelter in Santa Fe and, with the changing dynamic of the pandemic and the insecurity in housing during this crisis, offers a safe space for those facing homelessness or those testing positive with COVID-19.

Finally, many of the guests at Consuelo's Place Shelter are quite vulnerable and it takes a long time for them to build trust with their providers. Disrupting that dynamic with a new provider would not be in their best interests and likely lead to a number of them becoming homeless again.

***Approvals:**

Based on the above facts, the City of Santa Fe Purchasing Officer has made the determination that the justification for a Sole Source procurement is in accordance with the State Procurement Code, Section 13-1-126 Sole source procurement., NMSA 1978 and shall be posted for a 30-day period prior to award.

9.13.22

Fran Dunaway, CPO Date
Purchasing Officer for the
City of Santa Fe

Pursuant to the State Procurement Code, Section 13-1-126 Sole source procurement., NMSA 1978, the 30-day posting period of the Notice of Intent to Award this Sole Source request was met and no obligation to the award to the above referenced contractor were received. ***This Sole Source determination will be valid for a period of one (1) year from the date of the award.***

10/26/2022

Fran Dunaway, CPO **Date**
Purchasing Officer for the
City of Santa Fe

****Required Attachments:***

- ****Letter from Contractor acknowledging they are the only source (on their business letterhead and signed by the head of business or financial operations),***
- ****Quote from sole source Contractor***
- ****Agenda Item to be presented to City Council if over $60,000 for Professional Services and $60,000 for Goods and Non-Professional Services***

New Mexico Coalition to
End Homelessness

September 7, 2022

Fran Dunaway
Chief Purchasing Officer
City of Santa Fe
PO Box 909
Santa Fe, NM 87504

Dear Ms. Dunaway:

This letter is in regards to Consuelo's Place, a shelter for homeless people that the New Mexico Coalition to End Homelessness is the fiscal agent for and the $600,000 in ARPA funds necessary for operation of the shelter through June 30, 2023. Currently Consuelo's Place is the only non-congregate shelter and COVID-19 quarantine shelter in Santa Fe. This sole-source procurement is essential for providing non-congregate shelter to the most vulnerable homeless people and a safe quarantine space for people recovering from COVID-19.

Consuelo's Place was initially started by the City at the beginning of the Pandemic and then became a joint project of the City and NMCEH with NMCEH acting as fiscal agent and overseeing the operations through a shelter director. The guidance of NMCEH and the expertise of the current staff at Consuelo's are necessary for the continued smooth operation of the shelter. Without this continuity, we would lose the many positive outcomes now possible for the clients staying at Consuelo's Place.

We very much appreciate the City of Santa Fe joining us in the Consuelo's Place project, and we look forward to working with you. If need additional information do not hesitate to reach out to me at 505-992-9000 or Hank-H@nmceh.org.

Sincerely,

Hank Hughes
Executive Director

City of Santa Fe, New Mexico
Memorandum

DATE: November 7, 2022

TO: Governing Body
Finance Committee
Quality of Life Committee

VIA: John Blair, City Manager
Emily Oster, Finance Department Director
Joann Lovato, Contracts Supervisor
Manuel Gonzales, ITT Department Director MG

FROM: Michelle A. Gurule, Contracts Administrator

ITEM AND ISSUE:
ITT Department Request for the Approval of Phone Maintenance and Support Agreement in the Total Amount of $583,959.21 for 3 Years $194,653.07 Per Year for Phone Maintenance and Support Services; (Altura Communications and Solutions);(Manuel Gonzales mmgonzales@santafenm.gov 505-955-5576)

BACKGROUND AND SUMMARY:

This agreement covers software updates, licensing, general support and usage fees of the phone system software. This agreement is with Altura Communications Solutions who will be responsible for the Maintenance Services.

PROCUREMENT METHOD:

The procurement method is the NM Statewide Price Agreement (SWPA) # 70-361-17-02013AA which expireson April 30,2024.

CONTRACT NUMBER:
The FY23 Munis contract number is 3201719.

FUNDING SOURCE:

The funding source is:
Fund Name/Number: Services of Other Departments /Fund 620
Munis Org Name/Number: ITT EAS/6203600
Munis Object Name/Number: Software Subscriptions/530710

ACTION REQUESTED:
ITT respectfully requests your review and approval.

Item#_____
Munis Contract# 3201719

CITY OF SANTA FE
AMENDMENT No. 1 TO
Altura Communications Solutions Agreement
ITEM# 20-0041

This Amendment No. 1 (the "Amendment") amends the CITY OF SANTA FE Altura Communications Solutions Agreement dated December 31, 2019 (the "Agreement"), between the City of Santa Fe (the "City") and Altura Communications Solutions. (the "Contractor"). The date of this Amendment shall be the date when it is executed by the City and the Contractor whichever occurs last.

RECITALS:

A. Under the terms of the Agreement, Contractor has agreed to provide the Avaya Maintenance and Support Service 12/31/2022-12/31/2025.

B. Pursuant to Article 8 of the Agreement, and for good and valuable consideration, the receipt and sufficiency of which are acknowledged by the parties, the City and the Contractor agree as follows:

1. SCOPE OF SERVICES

Article 2 of the Agreement is amended to provide the Avaya Maintenance and Support Service 12/31/2022-12/31/2025, so that Article 2 reads as follows:

2) Altura shall provide the products, maintenance and support as stated in Schedule 1 Quote and Support Details as described in Exhibit B attached hereto.

2. COMPENSATION.

Article 3, paragraph A of the Agreement is amended to increase the amount of

compensation by a total of Five Hundred Thirty-Nine Thousand, One Hundred Forty-Two Dollars and Ninety-Six Cents ($539,142.96), so that Article 3, paragraph A reads in its entirety as follows:

The total compensation under this Amendment no. 1 is $583,959.21 including gross receipts tax. The breakdown per year is $194,653.07 including New Mexico gross receipts tax. The total compensation of this agreement shall not exceed $827,600.07.

- Compensation paid 12/31/2019-12/31/2022 $243,640.86
- Compensation to be paid 12/31/2022-12/31/2025 $583,959.21 ($194,653.07 per year)

3. TERM:

Article 5 of the Agreement is hereby deleted in its entirety and substitute the following Article 5 in its place:

THIS AGREEMENT SHALL NOT BECOME EFFECTIVE UNTIL APPROVED IN WRITING BY THE CITY. This Agreement shall begin on date approved by the City, and end on **12/31/2025.** The City reserves the right to renew the contract on an annual basis by mutual Agreement not exceed a total of four years in accordance with NMSA 1978, §§ 13-1-150 through 152.

4. AGREEMENT IN FULL FORCE.

Except as specifically provided in this Amendment, the Agreement remains and shall remain in full force and effect, in accordance with its terms.

IN WITNESS WHEREOF, the parties have executed this Amendment No. 1 to the Agreement as of the dates set forth below.

CITY OF SANTA FE:

_____
ALAN WEBBER, CITY MAYOR

DATE:_____

CONTRACTOR:
Tom Pickford

Tom Pickford
NAME

Vice President, Sales
TITLE

DATE: 11/1/2022
CRS#_____

Registration # _____

ATTEST:

_____
KRISTINE BUSTOS MIHELCIC, CITY CLERK

CITY ATTORNEY'S OFFICE:

Marcos Martinez
Marcos Martinez (Oct 28, 2022 13:53 MDT)
_____
SENIOR ASSISTANT CITY ATTORNEY

APPROVED FOR FINANCES:

_____
EMILY OSTER, FINANCE DIRECTOR
EAS Software Subscriptions/ 6203600.530710 AH
Org. Name/Org.#

Sales Order

Altura Communication Solutions

1540 S. Lewis St.
Anaheim, CA 92805

ALTURA communication solutions
A Waterfield company

Exhibit A – Order Form

Quote For MASTER SALES AND MAINTENANCE AGREEMENT ("Agreement") dated June 16, 2022 by and between Altura Communication Solutions, LLC and City of Santa Fe ('Customer')

PREMISES (INSTALLED AT):

City of Santa Fe

,

SERVICES PERFORMED FOR:

BillTo: City of Santa Fe -
City of Santa Fe

,

PRICING & DATES

Purchase Price *	$0.00
Support Paid Up-Front	$179,714.32
TOTAL	**$179,714.32**
Support to be billed	$359,428.64

** Includes installation and shipping if applicable, but excludes taxes*

Contract Presented	October 6, 2022
Delivery *	TBD
Installation Start *	TBD
Cutover *	TBD
In Service *	TBD

** Estimated*

ATTACHMENTS

- Coverpage
- Exhibit A, Exhibit B and Schedule 1
- Support Details

Upon execution by both parties, this Order Form shall be incorporated into the Agreement.

Altura Communication Solutions, LLC

By _____

Name _____

Title _____

Date _____

City of Santa Fe

By _____

Name _____

Title _____

Date _____

Schedule1 – Quote & Exhibit B

This quote is only good for 45 days, effective: **10/06/2022**.

Vendor	Description	Sale Price
Avaya	Avaya Support PP	$145,188.08
	Avaya Solutions and Support	**$145,188.08**
Altura	Advantage PP	$5,000.00
Other	Third Party Support PP	$29,526.24
	Other Solutions and Support	**$34,526.24**
	Solutions and Support Total	**$179,714.32**
	Due at Start of Support	**$179,714.32**
	TOTAL Solutions, Support And Installation	**$179,714.32**
Altura	**Advantage AN Y2+**	**$10,000.00**
Avaya	**Avaya Support AN Y2+**	**$290,376.16**
Other	**Third Party Support AN Y2+**	**$59,052.48**
	TOTAL SUPPORT To Be Paid	**$359,428.64**
	GRAND SOLUTION TOTAL	**$539,142.96**

All Pricing Excludes Taxes

Upon execution by both parties, this Schedule shall be incorporated into the Agreement.

Altura Communication Solutions, LLC	City of Santa Fe
By	**By**
Name	**Name**
Title	**Title**
Date	**Date**

Support Details

Part #	Description	Term	QTY	Location	Unit Sale	Sale Price
403564	AVAYA CC VOICE AGT LIC FIXED SUBS 5YRAN	36 months	92	Main	$17.28	$57,231.36
403546	AVAYA UC BASIC LIC FIXED SUBS 5YRAN	36 months	300	Main	$1.68	$18,144.00
403552	AVAYA UC CORE LIC FIXED SUBS 5YRAN	36 months	2732	Main	$2.48	$243,912.96
407015	AVAYA CC WE ACRA REC PKG LIC FIXED SUBS 5YRAN	36 months	70	Main	$9.60	$24,192.00
409500	AVAYA 911S-ENG-PROSERV	36 months	8	Main	$14.75	$4,248.00
409177	AVAYA 911 APS PKG - ALLIANCES PROJECT COORDINATION	36 months	1	Main	$126.67	$4,560.00
408174	AVAYA SENTRY NG911 RAPIDSOS ANL PREPAID	36 months	66	Main	$5.15	$12,236.40
408162	AVAYA SENTRY VPC ANL MIN CODE 250 FEE	36 months	1	Main	$258.00	$9,288.00
408195	AVAYA SENTRY DISPATCHER GATEKPR ANL SUPT	36 months	1	Main	$166.08	$5,978.88
408191	AVAYA SENTRY LIC ANL SUPT 1-5K ENDPT	36 months	1500	Main	$0.10	$5,400.00
408189	AVAYA SENTRY BECN ERL/ELE FLT ANL SP 100	36 months	1	Main	$149.42	$5,379.12
408184	AVAYA SENTRY BEACN ENT LIC 100 ANL SUPT	36 months	1	Main	$82.83	$2,981.88
408176	AVAYA SENTRY E911 ANL SUPT 1001 TO 2500	36 months	1	Main	$82.83	$2,981.88
408177	AVAYA SENTRY E911 AURA/SM SCOUT ANL SUPT	36 months	1	Main	$27.08	$974.88
408181	AVAYA SENTRY E911 INT/EXT/MAC ANL SUPT	36 months	1	Main	$27.08	$974.88
408122	AVAYA ANL EMRG CALL RESP CNTR 1K PLUS ENDPTS	36 months	1	Main	$1,030.00	$37,080.00
				Avaya Support PP		$145,188.08
				Avaya Support AN Y2+		$290,376.16
				AVAYA SUPPORT TOTAL		$435,564.24
Annual BOH	Altura Annual BOH For Support	36 months	25	Main	$16.67	$15,000.00
				Altura Advantage PP		$5,000.00
				Altura Advantage AN Y2+		$10,000.00
				ALTURA ADVANTAGE TOTAL		$15,000.00
Support	OPENTEXT 1YPP Xmedius RF Software Support and 1YPP AVST for SN 1474823111006 AN	36 months	1	Main	$46,254.60	$46,254.60
Support	OPENTEXT Fax Server AN	36 months	1	Main	$16,057.56	$16,057.56
Support	CI IVR SILVER - Total Care (Mon-Fri, 7-7 CST) AN	36 months	1	Main	$26,266.56	$26,266.56
				Other Support PP		$29,526.24
				Other Support AN Y2+		$59,052.48
				OTHER SUPPORT TOTAL		$88,578.72

AN = Annual Payment

PP = Prepaid Payment

The End Customer may terminate their Avaya Support Advantage Services at any time during the current term upon at least 45 days written notice and shall be subject to payment of: (i) Support Advantage charges up to and including the date of termination, and (ii) cancellation fees. Cancellation fees shall be equal to the greater of Support Advantage charges that would otherwise be payable for the affected Support Advantage coverage for the remainder of the year of the Term in effect as of the effective date of the termination OR, 50% of the remainder of the Term in effect as of the effective date of the termination. The parties agree that the cancellation fees are liquidated damages comprising a reasonable estimate of Altura's damages in the event of the Customer's early termination and are not a penalty. Unless already paid, the cancellation fees shall be immediately due and payable upon cancellation.

Maintenance Start Date

Due Upon Commencement of Manufacturer Support Contract

ITEM # 20-0041

City of Santa Fe Contract
Software Services

THIS AGREEMENT is made and entered into by and between the City of Santa Fe, herein after referred to as the "City", and **Altura Communications Solutions** herein after referred to as the "Contractor."

IT IS MUTUALLY AGREED BETWEEN THE PARTIES:

1. **Definitions**

A. "Products and Services Schedule" refers to the complete list of products and services offered under this Agreement and the price for each. Product and service descriptions may be amended with the prior approval of the Agreement Administrator. New products and services shall not be added to the Products and Services Schedule.

B. "Business Hours" means 8:00 a.m. to 5:00 p.m. Mountain Time.

C. "You" and "your" refers to **Altura Communications Solutions**. "We," "us" or "our" refers to the City and whose accounts are created under this Agreement.

2. **Scope of Work**

A. The Contractor shall provide the following:

1) Avaya Software Maintenance and License Renewal for 36 month term.

3. **Compensation**

The total compensation under this Agreement shall not exceed $243,640.86, including gross receipts tax as described in Exhibit "A" attached hereto and incorporated herein. The breakdown per year is $81,213.62, including New Mexico gross receipts tax.

4. **Payment Provisions**

All payments under this Agreement are subject to the following provisions.

A. Acceptance - In accordance with Section 13-1-158 NMSA 1978, the City shall determine if the product or services provided meet specifications. Until the products or services have been accepted in writing by the City, the City shall not pay for any products or services. Unless otherwise agreed upon between the City and the Contractor, within thirty (30) days from the date the City receives written notice from the Contractor that payment is requested for services or within thirty (30) days from the receipt of products, the City shall issue a written certification (by letter or email) of complete or partial acceptance or rejection of the products or services. Unless the City gives notice of rejection within the specified time period, the products or services will be deemed to have been accepted.

B. Payment of Invoice - Upon acceptance that the products or services have been received and accepted, payment shall be tendered to the Contractor within thirty (30) days after the date of invoice. After the thirtieth day from the date that written certification of acceptance is issued, late payment charges shall be paid on the unpaid balance due on the contract to the Contractor at the rate of 1.5 % per month. Contractor may submit invoices for payment no more frequently than monthly. Payment will be made to the Contractor's designated mailing address. Payment on each invoice shall be due within 30 days from the date of the acceptance of the invoice. The City agrees to pay in full the balance shown on each account's statement, by the due date shown on said statement.

5. **Term**

THIS AGREEMENT SHALL NOT BECOME EFFECTIVE UNTIL APPROVED IN WRITING BY THE CITY. This Agreement shall begin on date approved by the City, and end on **12/31/2022.** The City reserves the right to renew the contract on an annual basis by mutual Agreement not exceed a total of four years in accordance with NMSA 1978, §§ 13-1-150 through 152.

6. **Default and Force Majeure**

The City reserves the right to cancel all or any part of any orders placed under this contract without cost to the City, if the Contractor fails to meet the provisions of this contract and, except as otherwise provided herein, to hold the Contractor liable for any excess cost occasioned by the City due to the Contractor's default. The Contractor shall not be liable for any excess costs if failure to perform the order arises out of causes beyond the control and without the fault or negligence of the Contractor; such causes include, but are not restricted to, acts of God or the public enemy, acts of the State or Federal Government, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, unusually severe weather and defaults of sub-contractors due to any of the above, unless the City shall determine that the supplies or services to be furnished by the sub-contractor were obtainable from other sources in sufficient time to permit the Contractor to meet the required delivery scheduled. The rights and remedies of the City provided in this paragraph shall not be exclusive and are in addition to any other rights now being provided by law or under this contract.

7. **Termination**

A. Grounds. The City may terminate this Agreement for convenience or cause. The Contractor may only terminate this Agreement based upon the City's uncured, material breach of this Agreement.

B. Notice; City Opportunity to Cure.

1. Except as otherwise provided in Paragraphs 7.A and 17, the City shall give Contractor written notice of termination at least thirty (30) days prior to the intended date of termination.

2. Contractor shall give City written notice of termination at least thirty (30) days prior to the intended date of termination, which notice shall (i) identify all the City's material breaches of this Agreement upon which the termination is based and (ii) state what the City must do to cure such material breaches. Contractor's notice of termination shall only be effective (i) if the City does not cure all material breaches within the thirty (30) day notice period

or (ii) in the case of material breaches that cannot be cured within thirty (30) days, the City does not, within the thirty (30) day notice period, notify the Contractor of its intent to cure and begin with due diligence to cure the material breach.

3. Notwithstanding the foregoing, this Agreement may be terminated immediately upon written notice to the Contractor (i) if the Contractor becomes unable to perform the services contracted for, as determined by the City; (ii) if, during the term of this Agreement, the Contractor is suspended or debarred by the City; or (iii) the Agreement is terminated pursuant to Paragraph 17, "Appropriations", of this Agreement.

C. Liability. Except as otherwise expressly allowed or provided under this Agreement, the City's sole liability upon termination shall be to pay for acceptable work performed prior to the Contractor's receipt or issuance of a notice of termination; provided, however, that a notice of termination shall not nullify or otherwise affect either party's liability for pre-termination defaults under or breaches of this Agreement. The Contractor shall submit an invoice for such work within thirty (30) days of receiving or sending the notice of termination. *THIS PROVISION IS NOT EXCLUSIVE AND DOES NOT WAIVE THE CITY'S OTHER LEGAL RIGHTS AND REMEDIES CAUSED BY THE CONTRACTOR'S DEFAULT/BREACH OF THIS AGREEMENT.*

8. **Amendment**

A. This Agreement shall not be altered, changed or amended except by instrument in writing executed by the parties hereto and all other required signatories.

B. If the City proposes an amendment to the Agreement to unilaterally reduce funding due to budget or other considerations, the Contractor shall, within thirty (30) days of receipt of the proposed Amendment, have the option to terminate the Agreement, pursuant to the termination provisions as set forth in Paragraph 7 herein, or to agree to the reduced funding.

9. **Status of Contractor**

The Contractor, and Contractor's agents and employees, are independent Contractors for the City and are not employees of the City. The Contractor, and Contractor's agents and employees, shall not accrue leave, retirement, insurance, bonding, use of City vehicles, or any other benefits afforded to employees of the City as a result of this Agreement. The Contractor acknowledges that all sums received hereunder are personally reportable by the Contractor for income tax purposes, including without limitation, self-employment tax and business income tax. The Contractor agrees not to purport to bind the City unless the Contractor has written authority to do so, and then only within the strict limits of that authority.

10. **Assignment**

The Contractor shall not assign or transfer any interest in this Agreement or assign any claims for money due or to become due under this Agreement without the prior written approval of the City.

11. **Subcontracting**

The Contractor shall not subcontract any portion of the services to be performed under this Agreement without the prior written approval of the City. No such subcontract shall relieve

the primary Contractor from its obligations and liabilities under this Agreement, nor shall any subcontract obligate direct payment from the City.

12. **Non-Collusion**

In signing this Agreement, the Contractor certifies the Contractor has not, either directly or indirectly, entered into action in restraint of free competitive bidding in connection with this offer submitted to the City.

13. **Inspection of Plant**

The City may inspect, at any reasonable time during Contractor's regular business hours and upon prior written notice, the Contractor's plant or place of business, or any subcontractor's plant or place of business, which is related to the performance of this contract.

14. **Commercial Warranty**

The Contractor agrees that the tangible personal property or services furnished under this Agreement shall be covered by the most favorable commercial warranties the Contractor gives to any customer for such tangible personal property or services, and that the rights and remedies provided herein shall extend to the City and are in addition to and do not limit any rights afforded to the City by any other clause of this order. Contractor agrees not to disclaim warranties of fitness for a particular purpose or merchantability.

15. **Condition of Proposed Items**

Where tangible personal property is a part of this Agreement, all proposed items are to be NEW and of most current production, unless otherwise specified.

16. **Records and Audit**

During the term of this Agreement and for three years thereafter, the Contractor shall maintain detailed records pertaining to the services rendered and products delivered. These records shall be subject to inspection by the City, the State Auditor and other appropriate state and federal authorities. The City shall have the right to audit billings both before and after payment. Payment under this Agreement shall not foreclose the right of the City to recover excessive or illegal payments.

17. **Appropriations**

The terms of this Agreement, and any orders placed under it, are contingent upon sufficient appropriations and authorization being made by the City Council for the performance of this Agreement. If sufficient appropriations and authorization are not made by the legislature, this Agreement, and any orders placed under it, shall terminate upon written notice being given by the City to the Contractor. The City's decision as to whether sufficient appropriations are available shall be accepted by the Contractor and shall be final. If the City proposes an amendment to the Agreement to unilaterally reduce funding, the Contractor shall have the option to terminate the Agreement or to agree to the reduced funding, within thirty (30) days of receipt of the proposed amendment.

18. **Release**

The Contractor, upon final payment of the amount due under this Agreement, releases the City, its officers and employees, from all liabilities, claims and obligations whatsoever arising from or under this Agreement. The Contractor agrees not to purport to bind the City, unless the Contractor has express written authority to do so, and then only within the strict limits of that authority.

19. **Confidentiality**

Any confidential information provided to or developed by the Contractor in the performance of this Agreement shall be kept confidential and shall not be made available to any individual or organization by the Contractor without prior written approval by the City.

20. **Conflict of Interest**

A. The Contractor represents and warrants that it presently has no interest and, during the term of this Agreement, shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance or services required under the Agreement. The Contractor shall comply with any applicable provisions of the New Mexico Governmental Conduct Act and the New Mexico Financial Disclosures Act.

B. The Contractor further represents and warrants that it has complied with, and, during the term of this Agreement, will continue to comply with, and that this Agreement complies with all applicable provisions of the Governmental Conduct Act, Chapter 10, Article 16 NMSA 1978.

C. Contractor's representations and warranties in Paragraphs A and B of this Paragraph are material representations of fact upon which the City relied when this Agreement was entered into by the parties. Contractor shall provide immediate written notice to the City if, at any time during the term of this Agreement, Contractor learns that Contractor's representations and warranties in Paragraphs A and B of this Paragraph 20 were erroneous on the effective date of this Agreement or have become erroneous by reason of new or changed circumstances. If it is later determined that Contractor's representations and warranties in Paragraphs A and B of this Paragraph 20 were erroneous on the effective date of this Agreement or have become erroneous by reason of new or changed circumstances, in addition to other remedies available to the City and notwithstanding anything in the Agreement to the contrary, the City may immediately terminate the Agreement.

D. All terms defined in the Governmental Conduct Act have the same meaning in this section.

21. **Approval of Contractor Representative(s)**

The City reserves the right to require a change in Contractor representative(s) if the assigned representative(s) are not, in the opinion of the City, adequately serving the needs of the City.

22. **Scope of Agreement; Merger**

This Agreement incorporates all the agreements, covenants, and understandings between the parties hereto concerning the subject matter hereof, and all such covenants, agreements and understandings have been merged into this written Agreement. No prior agreements or understandings, verbal or otherwise, of the parties or their agents shall be valid or enforceable unless embodied in this Agreement.

23. **Notice**

The Procurement Code, Sections 13-1-28 through 13-1-199 NMSA 1978, imposes civil and criminal penalties for its violation. In addition, the New Mexico criminal statutes impose felony penalties for bribes, gratuities and kickbacks.

24. **Equal Opportunity Compliance**

The Contractor agrees to abide by all federal and state laws, and local Ordinances, pertaining to equal employment opportunity. In accordance with all such laws, rules, and regulations, the Contractor agrees to assure that no person in the United States shall on the grounds of race, religion, color, national origin, ancestry, sex, age, physical or mental handicap, or serious medical condition, spousal affiliation, sexual orientation or gender identity, be excluded from employment with or participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity performed under this Agreement. If Contractor is found not to be in compliance with these requirements during the life of this Agreement, Contractor agrees to take appropriate steps to correct these deficiencies.

25. **Indemnification**

The Contractor shall hold the City and its employees harmless and shall indemnify the City and its employees against any and all claims, suits, actions, liabilities and costs of any kind, including attorney's fees for personal injury or damage to property arising from the acts or omissions of the Contractor, its agents, officers, employees or subcontractors. The Contractor shall not be liable for any injury or damage as a result of any negligent act or omission committed by the City, its officers or employees.

26. **New Mexico Tort Claims Act**

Any liability incurred by the City of Santa Fe in connection with this Agreement is subject to the immunities and limitations of the New Mexico Tort Claims Act, Section 41-4-1, et. seq. NMSA 1978, as amended. The City and its "public employees" as defined in the New Mexico Tort Claims Act, do not waive sovereign immunity, do not waive any defense and do not waive any limitation of liability pursuant to law. No provision in this Agreement modifies or waives any provision of the New Mexico Tort Claims Act.

27. **Applicable Law**

The laws of the State of New Mexico shall govern this Agreement, without giving effect to its choice of law provisions. Venue shall be proper only in a New Mexico court of competent

jurisdiction in accordance with NMSA 1978, § 38-3-1 (G). By execution of this Agreement, Contractor acknowledges and agrees to the jurisdiction of the courts of the State of New Mexico over any and all lawsuits arising under or out of any term of this Agreement.

28. **Limitation of Liability**

The Contractor's liability to the City, for any cause whatsoever shall be limited to the purchase price paid to the Contractor for the products and services that are the subject of the City's, claim. The foregoing limitation does not apply to paragraph 25 of this Agreement or to damages resulting from personal injury caused by the Contractor's negligence.

29. **Incorporation by Reference and Precedence**

If this Agreement has been procured pursuant to a request for proposals, this Agreement is derived from (1) the request for proposal, (including any written clarifications to the request for proposals and any City response to questions); (2) the Contractor's best and final offer; and (3) the Contractor's response to the request for proposals.

In the event of a dispute under this Agreement, applicable documents will be referred to for the purpose of clarification or for additional detail in the following order of precedence: (1) amendments to the Agreement in reverse chronological order; (2) the Agreement, including the scope of work and all terms and conditions thereof; (3) the request for proposals, including attachments thereto and written responses to questions and written clarifications; (4) the Contractor's best and final offer if such has been made and accepted by the City; and (5) the Contractor's response to the request for proposals.

30. **Workers' Compensation**

The Contractor agrees to comply with state laws and rules applicable to workers' compensation benefits for its employees. If the Contractor fails to comply with the Workers' Compensation Act and applicable rules when required to do so, this Agreement may be terminated by the City.

31. **Inspection**

If this contract is for the purchase of tangible personal property (goods), final inspection and acceptance shall be made at Destination. Tangible personal property rejected at Destination for non-conformance to specifications shall be removed at Contractor's risk and expense promptly after notice of rejection and shall not be allowable as billable items for payment.

32. **Inspection of Services**

If this contract is for the purchase of services, the following terms shall apply.

A. Services, as used in this Article, include services performed, workmanship, and material furnished or utilized in the performance of services.

B. The Contractor shall provide and maintain an inspection system acceptable to the City covering the services under this Agreement. Complete records of all inspection work performed by the Contractor shall be maintained and made available to the City and for as long

thereafter as the Agreement requires. The City has the right to inspect and test all services contemplated under this Agreement to the extent practicable at all times and places during the term of the Agreement. The City shall perform inspections and tests in a manner that will not unduly delay or interfere with Contractor's performance.

C. If the City performs inspections or tests on the premises of the Contractor or a subcontractor, the Contractor shall furnish, and shall require subcontractors to furnish, at no increase in contract price, all reasonable facilities and assistance for the safe and convenient performance of such inspections or tests.

D. If any part of the services do not conform with the requirements of this Agreement, the City may require the Contractor to re-perform the services in conformity with the requirements of this Agreement at no increase in contract amount. When the defects in services cannot be corrected by re-performance, the City may:

(1) require the Contractor to take necessary action(s) to ensure that future performance conforms to the requirements of this Agreement; and

(2) reduce the contract price to reflect the reduced value of the services performed.

E. If the Contractor fails to promptly re-perform the services or to take the necessary action(s) to ensure future performance in conformity with the requirements of this Agreement, the City may:

(1) by contract or otherwise, perform the services and charge to the Contractor any cost incurred by the City that is directly related to the performance of such service; or

(2) terminate the contract for default.

33. Insurance

If the services contemplated under this Agreement will be performed on or in City facilities or property, Contractor shall maintain in force during the entire term of this Agreement, the following insurance coverage(s), naming the City as additional insured.

A. Workers Compensation (including accident and disease coverage) at the statutory limit. Employers liability: $100,000.

B. Comprehensive general liability (including endorsements providing broad form property damage, personal injury coverage and contractual assumption of liability for all liability the Contractor has assumed under this contract). Limits shall not be less than the following:

a. Bodily injury: $1,000,000 per person /$1,000,000 per occurrence.
b. Property damage or combined single limit coverage: $1,000,000.
c. Automobile liability (including non-owned automobile coverage): $1,000,000.
d. Umbrella: $1,000,000.

C. Contractor shall maintain the above insurance for the term of this Agreement and name the City as an additional insured and provide for 30 days cancellation notice on any Certificate of Insurance form furnished by Contractor. Such certificate shall also specifically state the coverage provided under the policy is primary over any other valid and collectible insurance and provide a waiver of subrogation.

34. Impracticality of Performance

A party shall be excused from performance under this Agreement for any period that the party is prevented from performing as a result of an act of God, strike, war, civil disturbance,

epidemic, or court order, provided that the party has prudently and promptly acted to take any and all steps that are within the party's control to ensure performance. Subject to this provision, such non-performance shall not be deemed a default or a ground for termination.

35. **Invalid Term or Condition**

If any term or condition of this Agreement shall be held invalid or unenforceable, the remainder of this Agreement shall not be affected and shall be valid and enforceable.

36. **Enforcement of Agreement**

A party's failure to require strict performance of any provision of this Agreement shall not waive or diminish that party's right thereafter to demand strict compliance with that or any other provision. No waiver by a party of any of its rights under this Agreement shall be effective unless express and in writing, and no effective waiver by a party of any of its rights shall be effective to waive any other rights.

37. **Patent, Copyright and Trade Secret Indemnification**

A. The Contractor shall defend, at its own expense, the City against any claim that any product or service provided under this Agreement infringes any patent, copyright to trademark in the United States or Puerto Rico, and shall pay all costs, damages and attorneys' fees that a court finally awards as a result of any such claim. In addition, if any third party obtains a judgment against the City based upon Contractor's trade secret infringement relating to any product or services provided under this Agreement, the Contractor agrees to reimburse the City for all costs, attorneys' fees and amount of the judgment. To qualify for such defense and or payment, the City shall:

i. give the Contractor prompt written notice within 48 hours of any claim;

ii. allow the Contractor to control the defense of settlement of the claim; and

iii. cooperate with the Contractor in a reasonable way to facilitate the defense or settlement of the claim.

B. If any product or service becomes, or in the Contractor's opinion is likely to become the subject of a claim of infringement, the Contractor shall at its option and expense:

i. provide the City the right to continue using the product or service and fully indemnify the City against all claims that may arise out of the City's use of the product or service;

ii. replace or modify the product or service so that it becomes non-infringing; or,

iii. accept the return of the product or service and refund an amount equal to the value of the returned product or service, less the unpaid portion of the purchase price and any other amounts, which are due to the Contractor. The Contractor's obligation will be void as to any product or service modified by the City to the extent such modification is the cause of the claim.

38. **Survival**

The Agreement paragraphs titled "Patent, Copyright, Trademark, and Trade Secret Indemnification; Indemnification; and Limit of Liability" shall survive the expiration of this Agreement. Software licenses, leases, maintenance and any other unexpired Agreements that were entered into under the terms and conditions of this Agreement shall survive this Agreement.

39. **Disclosure Regarding Responsibility**

A. Any prospective Contractor and any of its Principals who enter into a contract greater than sixty thousand dollars ($60,000.00) with any City for professional services, tangible personal property, services or construction agrees to disclose whether the Contractor, or any principal of the Contractor's company is presently debarred, suspended, proposed for debarment, or declared ineligible for award of contract by any federal entity, state agency or local public body.

B. Principal, for the purpose of this disclosure, means an officer, director, owner, partner, or a person having primary management or supervisory responsibilities within a business entity or related entities.

C. The Contractor shall provide immediate written notice to the City if, at any time during the term of this Agreement, the Contractor learns that the Contractor's disclosure was at any time erroneous or became erroneous by reason of changed circumstances.

D. A disclosure that any of the items in this requirement exist will not necessarily result in termination of this Agreement. However, the disclosure will be considered in the determination of the Contractor's responsibility and ability to perform under this Agreement. Failure of the Contractor to furnish a disclosure or provide additional information as requested will be grounds for immediate termination of this Agreement pursuant to the conditions set forth in Paragraph 7 of this Agreement.

E. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render, in good faith, the disclosure required by this document. The knowledge and information of a Contractor is not required to exceed that which is the normally possessed by a prudent person in the ordinary course of business dealings.

F. The disclosure requirement provided is a material representation of fact upon which reliance was placed when making an award and is a continuing material representation of the facts during the term of this Agreement. If during the performance of the contract, the Contractor is indicted for or otherwise criminally or civilly charged by any government entity (federal, state or local) with commission of any offenses named in this document the Contractor must provide immediate written notice to the City. If it is later determined that the Contractor knowingly rendered an erroneous disclosure, in addition to other remedies available to the Government, the City may terminate the involved contract for cause. Still further the City may suspend or debar the Contractor from eligibility for future solicitations until such time as the matter is resolved to the satisfaction of the City.

40. **Suspension, Delay or Interruption of Work**

The City may, without cause, order the Contractor, in writing, to suspend, delay or interrupt the work in whole or in part for such period of time as the City may determine. The contract sum and contract time shall be adjusted for increases in cost and/or time associated with Contractor's compliance therewith. Upon receipt of such notice, Contractor shall leave the jobsite and any equipment in a safe condition prior to departing. Contractor must assert rights to additional compensation within thirty (30) days after suspension of work is lifted and return to

work is authorized. Any compensation requested for which entitlement is granted and the contract sum adjusted, shall have profit included (for work completed) and for cost only (not profit) for Contractor costs incurred directly tied to the suspension itself and not otherwise covered by Contract remedy. Any change in Total Compensation must be reflected in an Amendment executed pursuant to Section 8 of this Agreement.

41. **Notification**

Either party may give written notice to the other party in accordance with the terms of this Paragraph. Any written notice required or permitted to be given hereunder shall be deemed to have been given on the date of delivery if delivered by personal service or hand delivery or three (3) business days after being mailed.

To the City:
David Tapia
City of Santa Fe
200 Lincoln Ave
Santa Fe, NM 87501

To the Contractor:
Gretchen Witti
Altura Communications Solutions
~~**1570 Pacheco Street, Suite B-6**~~ 2074 GALISTEO ST, B-5 MK
Santa Fe, NM 87505

Either party may change its representative or address above by written notice to the other in accordance with the terms of this Paragraph. The carrier for mail delivery and notices shall be the agent of the sender.

To the Contractor:
Gretchen Witti
Altura Communications Solutions
~~**1570 Pacheco Street, Suite B-6**~~ 2074 GALISTEO ST, B-5 MK
Santa Fe, NM 87505

Either party may change its representative or address above by written notice to the other in accordance with the terms of this Paragraph. The carrier for mail delivery and notices shall be the agent of the sender.

42. **Succession**

This Agreement shall extend to and be binding upon the successors and assigns of the parties.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the date of the signature by the required approval authorities below.

CITY OF SANTA FE:

ALAN WEBBER, MAYOR

DATE: 2/3/20

CONTRACTOR:
Altura Communications Solutions

NAME AND TITLE
DAVID KEY, CHIEF FINANCIAL OFFICER
DATE: 11/14/19
CRS# 02-491372-00-9
Registration # 18-00001379

ATTEST:

YOLANDA Y. VIGIL, CITY CLERK
ccmtg 1/29/20

APPROVED AS TO FORM:

11/12/19
ERIN K. MCSHERRY, CITY ATTORNEY

APPROVED:

1/30/20
MARY MCCOY, FINANCE DIRECTOR

620300.530710
~~Business Unit~~ Line Item
OPS/OBJ

ALTURA
communication solutions
A Platinum Equity Company

Customer Name:	City of Santa Fe ITT Division
Premises Information (install site) -	-
Street Address:	2651 Siringo Road
City:	Santa Fe
State:	NM
Zip Code:	87505
Customer Contact Name:	Edward Romero
omer Contact Phone:	505-955-5567

QUOTE FOR City of Santa Fe Annual Avaya Support

Quantity	Mat/ SAP Code	System/Service Description	SPD List Monthly Price	SPD Disc Monthly Total	SPD discounted Annual Total
100	291920	SA PREF AES R7 BSC TSAPI 3YAN	$ 26.00	$ 19.50	$ 234.00
100	292100	SA PREF AES R7 DMCC BASIC 3YAN	$ 26.00	$ 19.50	$ 234.00
100	291926	UPG ADV AES R7 BSC TSAPI 3YAN	$ 20.00	$ 15.00	$ 180.00
100	292106	UPG ADV AES R7 DMCC BASIC 3YAN	$ 20.00	$ 15.00	$ 180.00
300	292473	SA PREF AURA R7 ANALOG 3YAN	$ 78.00	$ 58.50	$ 702.00
2009	292587	SA PREF AURA R7 FOUNDATION 3YAN	$ 2,953.23	$ 2,214.92	$ 26,579.07
200	292606	SA PREF AURA R7 CORE 3YAN	$ 436.00	$ 327.00	$ 3,924.00
300	292480	UPG ADV AURA R7 ANALOG 3YAN	$ 60.00	$ 45.00	$ 540.00
2009	292594	UPG ADV AURA R7 FOUNDATION 3YAN	$ 2,270.17	$ 1,702.63	$ 20,431.53
200	292613	UPG ADV AURA R7 CORE 3YAN	$ 300.00	$ 225.00	$ 2,700.00
92	291729	SA PREF CC R7 ELITE AGT 3YAN	$ 486.68	$ 365.01	$ 4,380.12
92	291736	UPG ADV CC R7 ELITE AGT 3YAN	$ 299.00	$ 224.25	$ 2,691.00
92	293110	SA PREF CMS R18 AGT 1-250 3YAN	$ 175.72	$ 131.79	$ 1,581.48
20	293200	SA PREF CMS R18 SUPERVISOR 3YAN	$ 108.80	$ 81.60	$ 979.20
1	293212	SA PREF CMS R18 INITIAL ACD 3YAN	$ -	$ -	$ -
92	293116	UPG ADV CMS R18 AGT 1-250 3YAN	**$ 299.00**	$ 224.25	$ 2,691.00
1	284959	SA PREF ADS SAL GTWY OVA	$ -	$ -	$ -
1	284960	UPG ADV ADS SAL GTWY OVA	$ -	$ -	$ -
70	295955	SA PREF WFO R15 CR PKG 3YAN	$ 559.30	$ 419.48	$ 5,033.70
70	295961	UPG ADV WFO R15 CR PKG 3YAN	$ 203.70	$ 152.78	$ 1,833.30
		Jan 1, 2020 - Dec 31, 2020			**$ 74,894.40**
		Jan 1, 2021- Dec 31, 2021			$ 74,894.40
Purchase Price		Jan 1, 2022- Dec 31, 2022			$ 74,894.40
Tax in Santa Fe @ 8.4375%					**$ 6,319.22**
ALL PRICING INCLUDING TAXES		**Purchase price plus taxes for 1/1/2020-12/31/2020**			**$ 81,213.62**
	Pricing good for 60 days				

SPD# 70-361-17-02013 Exp 4/30/20

ALTURA COMMUNICATION SOLUTIONS, LLC		City of Santa Fe
BY:		BY:
NAME: Gretchen Witti		NAME:
TITLE: Strategic Sales		TITLE:
DATE: 10/29/19		DATE:

Exhibit "A"

State of New Mexico
General Services Department
Purchasing Division

Price Agreement Amendment REVISED Cover Page

Awarded Vendor: **0000013216** **Altura Communications Solutions** **1335 S. Acacia Avenue** **Fullerton, CA 92831** **Attention: David Key** **Telephone No.: (714) 948-8585**

Ship To: **Per Language Below**
Invoice: **As Requested**
For questions regarding this Price Agreement please contact: **Phil Bachicha (505) 476-3469**

Price Agreement Number**:** **70-361-17-02013AA**

Amendment No.**:** **One**

Term: **May 30, 2018 – April 30, 2024**

Procurement Specialist**:** **Vanessa LeBlanc**

Telephone No.**:** **(505) 827-0266**

Email: **Vanessa.LeBlanc@state.nm.us**

Title**:** **Telephony Equipment, Software and Related Services**

This Price Agreement Amendment is to be attached to the respective Price Agreement and become a part thereof.

In accordance with Price Agreement provisions, and by mutual agreement of all parties, this Price Agreement is extended from May 1, 2020 to April 30, 2024 at the same price, terms and conditions.

This is a *Department of Information Technology Agreement*, per statute of the Department of Information Technology Act, executive, legislative, and judicial branches of government and other governmental entities except those that are exempt by law must go through DoIT for any telephony services or shall request written approval from DoIT requesting an exemption. For exemptions, a request must be submitted through the DoIT's Enterprise Help Desk.

For the governmental entities that receive an approved written DoIT exemption, DoIT will not be responsible for any transactions with that procuring entity. As a result of the DoIT written approved exemption, DOIT will require from the procuring entity the fully executed contract between the procuring entity and the Contractor. The Contractor must not fully execute any binding contracts for services awarded in this Agreement without the DoIT written approved exemption allowing the governmental entity to contract directly with the Contractor. If the Contractor contracts their services to a governmental entity that does not have an approved written exemption from DoIT, DoIT may terminate the Agreement with the Contractor for cause.

Except as modified by this amendment, the provisions of the Price Agreement shall remain in full force and effect.

STATE OF NEW MEXICO
DEPARTMENT OF INFORMATION TECHNOLOGY
Department of Information Technology Price Agreement
DoIT Price Agreement No. 70-361-17-02013AA
AMENDMENT No. 1

THIS Amendment No. 1 (this "Amendment") to the Information Technology Agreement ("Agreement" or "Contract") is made by and between the **Department of Information Technology** hereinafter referred to as the "Procuring Agency" and **Altura Communications Solutions,** hereinafter referred to as the "Contractor" and collectively referred to as the "Parties".

The purpose of this amendment is to renew the agreement that expires on April 30, 2020 for four (4) additional years through April 30, 2024.

IT IS MUTUALLY AGREED BETWEEN THE PARTIES THAT THE FOLLOWING PROVISIONS OF THE AGREEMENT ARE AMENDED AS FOLLOWS:

1. **ARTICLE 5 – TERM.** THIS AGREEMENT SHALL NEITHER BE EFFECTIVE NOR BINDING UNTIL APPROVED BY THE DoIT AND THE STATE PURCHASING AGENT. This Agreement shall terminate on April 30, 2024 with no option to renew.

All other Articles of the original DoIT Price Agreement No. 70-361-17-02013AA remain unchanged.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the date of the signature by the required approval authorities below.

By: _____ Date: _____
David Key, Chief Financial Officer
Altura Communications Solutions

Approved for legal sufficiency:

By: _____ Date: 1/14/20
John Mares, General Counsel
Department of Information Technology

The records of the Taxation and Revenue Department reflect that the Contractor is registered with the Taxation and Revenue Department of the State of New Mexico to pay gross receipts and compensating taxes:

Taxation and Revenue is only verifying the registration and will not confirm or deny taxability statements contained in this contract.

CRS ID Number: 02-481372-009

By: Sheila Rohde Date: 01.10.20
Taxation & Revenue Department

Approved as to information technology contractual specifications and compliance with the Department of Information Technology Act, Chapter 9, Article 27 NMSA 1978 and Executive Orders relating to Information Technology issued by the Governor of the State of New Mexico.

By: Vincent Martinez, CIO Date: 1/14/20
Vincent Martinez, Cabinet Secretary and State Chief Information Officer
Department of Information Technology

This Agreement has been approved by the State Purchasing Agent:

By: _____ Date: 2/28/2020
Mark R. Hayden, State Purchasing Agent
for the State of New Mexico

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the date of the signature by the required approval authorities below.

By: _____ Date: 1/21/20
David Key, Chief Financial Officer
Altura Communications Solutions

Approved for legal sufficiency:

By: _____ Date: _____
John Mares, General Counsel
Department of Information Technology

The records of the Taxation and Revenue Department reflect that the Contractor is registered with the Taxation and Revenue Department of the State of New Mexico to pay gross receipts and compensating taxes:

CRS ID Number: 02-481372-009

By: _____ Date: _____
Taxation & Revenue Department

Approved as to information technology contractual specifications and compliance with the Department of Information Technology Act, Chapter 9, Article 27 NMSA 1978 and Executive Orders relating to Information Technology issued by the Governor of the State of New Mexico.

By: _____ Date: _____
Vincent Martinez, Cabinet Secretary and State Chief Information Officer
Department of Information Technology

This Agreement has been approved by the State Purchasing Agent:

By: _____ Date: _____
Mark R. Hayden, State Purchasing Agent
for the State of New Mexico

State of New Mexico
General Services Department

Statewide Price Agreement

Awarded Contractor
0000013216
Altura Communications Solutions
1335 S. Acacia Avenue
Fullerton, CA 92831

Attn: David Key
Telephone: 714-948-8585

Price Agreement Number: **70-361-17-02013AA**

Payment Terms: **Net 30**

F.O.B.: **Destination**

Delivery: **See Contract**

Ship To:
All State of New Mexico agencies, Commissions, Institutions, Political Subdivisions and Local Public Bodies allowed by law.

Invoice:
As Requested

Procurement Specialist: Debra Saiz

Telephone No.: 505-827-0521

Title: **Telephony Equipment, Software and Related Services**

Term: **May 30, 2018 through April 30, 2020**

This Price Agreement is made subject to the "terms and conditions" shown on the attached pages as indicated in this Price Agreement.

Accepted for the State of New Mexico

New Mexico State Purchasing Agent

Date: May 30, 2018

State of New Mexico

DEPARTMENT OF INFORMATION TECHNOLOGY PRICE AGREEMENT
Telephony Equipment, Software, and Related Services
Agency Price Agreement No. 70-361-17-02013AA
For Manufacturer Type: Avaya
To Include
Other Manufacturer Types:
Fujitsu, AVST, Genesys, Enghouse, Five9s, GenBand, Xima

THIS Information Technology Agreement ("Agreement" or "Contract") is made by and between the State of New Mexico, **Department of Information Technology**, hereinafter referred to as the "Procuring Agency" and **Altura Communications Solutions** hereinafter referred to as the "Contractor" and collectively referred to as the "Parties".

WHEREAS, pursuant to the Procurement Code, NMSA 1978 13-1-28 *et. seq*; and Procurement Code Regulations, NMAC 1.4.1 *et.seq*; the Contractor has held itself out as expert in implementing the Scope of Work as contained herein and the Procuring Agency has selected the Contractor as the offeror most advantageous to the State of New Mexico; and

WHEREAS, all terms and conditions of the RFP# 70-361-17-02013, "Telephony Equipment, Software, and Related Services" and the Contractor's response to such document(s) are incorporated herein by reference; and

NOW, THEREFORE, IT IS MUTUALLY AGREED BETWEEN THE PARTIES:

ARTICLE 1 – DEFINITIONS

A. "Acceptance" or "Accepted" shall mean the approval, after Quality Assurance, of all Deliverables by an Executive Level Representative of the Procuring Agency.
B. "Application Deployment Package" shall mean the centralized delivery of business critical applications including the source code (for custom software), documentation, executable code and deployment tools required to successfully install application software fixes including additions, modifications, or deletions produced by the Contractor.
C. "Business Days" shall mean Monday through Friday, 7:30 a.m. (MST or MDT) to 5:30 p.m. except for federal or state holidays.
D. "Change Request" shall mean the document utilized to request changes or revisions in the Scope of Work – Exhibit A, attached hereto and incorporated herein.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the date of the signature by the required approval authorities below.

By: _____ Date: 8 MAY 2018
Darryl M. Ackley, State CIO and Cabinet Secretary
Department of Information Technology

By: _____ Date: 4/17/18
David Key, Chief Financial Officer
Altura Communications Solutions

Approved for legal sufficiency:

By: _____ Date: May 8 2018
Maria R. Sanchez
Department of Information Technology, General Counsel

By: NOT APPLICABLE Date: _____
Donna Sandoval
Department of Information Technology, Chief Financial Officer

The records of the Taxation and Revenue Department reflect that the Contractor is registered with the Taxation and Revenue Department of the State of New Mexico to pay gross receipts and compensating taxes:

CRS ID Number: 02-481372-00

Taxation and Revenue is only verifying the registratio and will not confirm or deny any taxability statements contained in this contract.

By: _____ Date: 4/30/18
Taxation & Revenue Department

Approved as to information technology contractual specifications and compliance with the Department of Information Technology Act, Chapter 9, Article 27 NMSA 1978 and Executive Orders relating to Information Technology issued by the Governor of the State of New Mexico.

By: _____ Date: 8 MAY 2018
Darryl M. Ackley, State CIO and Cabinet Secretary
Department of Information Technology

This Agreement has been approved by the State Purchasing Agent:

By: _____ Date: 5/30/18
Lawrence O. Maxwell
Purchasing Agent for the State of New Mexico

APPENDIX C-1: TELEPHONY PROFESSIONAL SERVICE COST SCHEDULE

a. "**Level One**" means a qualified team member that has greater than ten (10) years of relevant past experience.
b. "**Level Two**" means a qualified team member that has five (5) to ten (10) years of relevant past experience.
c. "**Level Three**" means a qualified team member that has less than five (5) years of relevant past experience.

		Telephony Professional Services Maximum Hourly Rate(s)			
No.	**Professional Service Title**	**Manufacturer Type**	**2) Professional Service Description**	**3) Onsite Maximum Hourly Rate ($)**	**4) Offsite Maximum Hourly Rate ($)**
1	**Title: Design/ Programming Engineer**	Avaya	Provides software, hardware, Cloud and virtualization design services for complex voice, data and video networks. Also provides programming and development for IVR, CTI, SIP and UC projects. Designs all aspects of contact centers including but not limited to inbound, outbound, omni-channel, reports, message blasts, call and screen recording, auto call back, forecasting. Other services such as voice recognition, voice print.		
a	Level One			$ 400.00	$ 325.00
b	Level Two			$ NA	$ NA
c	Level Three			$ 175.00	$ 125.00
2	**Title: Technical Business Consultant**	Avaya	Provides technical and business analyses. Works with business units and IT/telephony departments to maximize benefits of technology, strategic plans and create ROIs.		
a	Level One			$ 300.00	$ 225.00
b	Level Two			$ NA	$ NA
c	Level Three			$ 175.00	$ 125.00
3	**Title: Technical Expert**	Avaya	Provides troubleshooting for complex voice, data and video equipment and networks: maximizes existing network performance/optimization. Performs risk and vulnerability assessments for voice, data and application networks. Designs and implements encryption plans.		
a	Level One			$ 600.00	$ 525.00
b	Level Two			$ NA	$ NA
c	Level Three			$ 250.00	$ 175.00
4	**Title: Professional Trainer**	Avaya	Subject Matter Expert provides user and system administration training on all applications Altura installs and maintains. May also provide creation of custom documentation as well as preparing, scheduling, arranging classroom space, materials and demo equipment.		
a	Level One			$ 300.00	$. 225.00
b	Level Two			$ NA	$ NA
c	Level Three			$ 175.00	$ 125.00

APPENDIX C-2 –Telephony Training Course(s) Pricing Schedule

*#	Course Name	Manu-facturer Type	Type of Course (Webinar, Onsite, Other)	Brief Description	Prerequisites, if any	Number of Days	Min and Max Class Size	Special Requests for Equipment, Connectivity, or Other	Cost per person including discounts
1	CMS reports	Avaya	Webinar	Supervisor training for reading CMS reports		4 hours	2/6	Connectivity to CMS group reports for supervisors needing training	$200
2	CMS customized reports	Avaya	Webinar	Supervisor training for creating customized reports	Basic CMS report understanding	8 hours	2/6	Connectivity to CMS group reports for supervisors needing training	$300
3	Experience Portal Admin	Avaya	Webinar	Training for management of EP reports		4 hours	2/6	Connectivity to EP reports for supervisors needing training	$200
4	Call Recording	Avaya	Webinar	Supervisor training for searching and listening to recorded calls on WFO		2 hours	2/6	Connectivity to WFO data for supervisors needing training	$200
5	Contact Center	Avaya	Webinar or on-site	Basic Supervisor and agent training .		1 hour	1/12	Access to supervisor PC and agent telephone	$100
5	AVST mailbox user training	AVST	Webinar or on-site	Basic mailbox training		1 hour	4/20	Access to live AVST voice mailbox	$100
6	Customized training for any product Altura sells	Avaya but also any products Altura sells, installs and maintains	Webinar or on-site	Classes tailored to meet DoIT and agency needs	Dependent on level of knowledge needed for student to get most benefit from class	TBD	TBD	TBD	TBD – based on hourly trainer prices in appendix C1

APPENDIX C-3: TELEPHONY LEASING OPTIONS COST SCHEDULE
(Only for Equipment over $25,000)

NOT APPLICABLE

No.	*Equipment Type	Manufacturer Type	Leasing Options		Leasing Term Cost including any discounts			
			Fair Market Value (Y, N)	$1 buyout (Y, N)	Year 1-2 ($)	Year 3-4 ($)	Year 5-6 ($)	Year 7-8 ($)
1								
2								

*Equipment leasing requires the use of the Master Lease Agreement as outlined in Article 34

APPENDIX C-4: TELEPHONY LEASING OPTIONS COST SCHEDULE
(Only for Equipment under $25,000)
NOT APPLICABLE

No.	*Equipment Type	Manufacturer Type	Leasing Options		Leasing Term Cost including any discounts			
			Fair Market Value (Y, N)	$1 buyout (Y, N)	Year 1-2 ($)		Year 3-4 ($)	
1								
2								

*Equipment leasing requires the use of the Master Lease Agreement as outlined in Article 34

APPENDIX C-5: Telephone System Features Cost Schedule

No.	Telephony Features	Feature Availability		Description of Feature	Cost ($) for Optional features	Manufacturer Type
		Subscription Services (X)	Optional (X)			
	Telephony Features *Offeror may add other features available					Avaya
	Elite Agent	no	x	Contact Center agent License –avail prem & subscription	$650.00	Avaya
	Elite Multichannel	no	x	Multichannel Agent License-prem & subscription	$575.00	Avaya
	Avaya Aura Power Suite License	x		Power license includes mobility and conferencing-avail prem & subscription	$400.00	Avaya
	Avaya Aura Core Suite License	x		Core User License avail prem &subscription	$300.00	Avaya
	Communication Manger Messaging	no	x	Internal voicemail. Avail prem & subscription	$0.00	Avaya
	CMS Agent	no	x	Agent Reporting License Avail prem & subscription	$650.00	Avaya
	CMS Supervisor	no	x	Reporting Supervisor License- avail prem and subscription	$850.00	Avaya
	WFO Desktop Analytics	no	x	Desktop screen capture analytics – avail prem &subscription	$277.00	Avaya
	WFO Advanced Speech Analytics	no	x	Speech Analytics- avail prem & subscription	$764.00	Avaya
	WFO Advanced Speech Analytics – Additional Language	no	x	Additional Language for Speech Analytics avail prem & subscription	$498.00	Avaya
	WFO Advanced Customer Feedback	no	x	Scorecards- avail prem and Subscription	$387.00	Avaya
	WFO CR to Optimization			Upgrade from recording to WFO- avail prem & subscription	$875.00	Avaya
	ScSc Cloud Powered by Avaya IPO Set-Up	no one time fee		Cloud Service set up	$495.00	Avaya

No.	Telephony Features	Feature Availability		Description of Feature		
		Subscription Services (X)	Optional (X)		Cost ($) for Optional features	Manufacturer Type
	ScSc Cloud Telephony + Solution	x		Basic Telephony user license	$19.75	Avaya
	ScSc Cloud Advanced UC Solution	x	x	Advanced UC telephony user license	$23.25	Avaya
	Telecom SIP Trunking	x	x	Carrier Services	$5.25	Avaya
	ScSc Cloud Contact Recorder Bundle	x	x	Recording	$100.00	Avaya
	Archival tier 500GB storage add-on	x	x	Addition storage option for recording	$105.00	Avaya
	Directory Listing Set-Up Charge			Directory setup	$15.00	Avaya
	Directory Listing Monthly	x		Directory Listing	$2.00	Avaya
	ScSc Cloud IPOCC Voice Agent Bundle	x	x	Contact Center Agent license (voice only)	$80.00	Avaya
	Cloud IPOCC Multi-Channel Agent Bundle (voice incl)	x	x	Multichannel and voice agent license	$99.00	Avaya
	ScSc Cloud IPOCC Supervisor Bundle	x	x	Contact Center Supervisor License	$60.00	Avaya
	Configuration and Installation Custom Quote			Quote to install and configure	Custom Quote	Avaya

Telephony Equipment, Software, and Related Services Maintenance & Support Pricing Continued

2. Moves, Adds, Changes, and Disconnects Hourly Rates:

No.	Description	Hourly Rate ($) (Onsite)	Hourly Rate (Offsite)/Remote
30.b	Moves, Adds, and Changes (MAC) Hourly Labor Rates		
	Management	**$125.00**	**$150.00**
	Engineering	**$175.00**	**$225.00**
	Administrative/Logistics	**$65.00**	**$65.00**
	Technician/Craft – All types	**$88.00**	**$99.00**
	Mileage: Reference the definition of Mileage as outlined in Article 1 of this Agreement	**$88.00 a visit and must not to exceed the cost per the definition of mileage**	**Not Applicable**

3. Annual Software Upgrades and Support Pricing:

No.	Description	*Annual Cost ($)
30.c	Annual Software Upgrades and Support	$299,404.07

*Includes Labor

CITY OF SANTA FE PROCUREMENT CHECKLIST

Contractor Name: Altura Communicatons Solutions

Procurement Title: SPA 70-361-17-02013AA Expires 04/30/24

Procurement Method: State Price Agreement [•] Cooperative [ ] Sole Source [ ] Other [ ]

Exempt [ ] Request For Proposal (RFP) [ ] Invitation To Bid (ITB) [ ] Contract under 60K [ ] Contract over 60K [•]

Department Requesting ITT Staff Name Michelle A. Gurule

Procurement Requirements:

A procurement file shall be maintained for all contracts, regardless of the method of procurement. The procurement file shall contain the basis on which the award is made, all submitted bids, all evaluation materials, score sheets, quotations and all other documentation related to or prepared in conjunction with evaluation, negotiation, and the award process. The procurement shall contain a written determination from the Requesting Department, signed by the purchasing officer, setting forth the reasoning for the contract award decision before submitting to the Committees.

REQUIRED DOCUMENTS FOR APPROVAL BY PURCHASING*

YES	N/A	
[•]	[ ]	Approved Procurement Checklist (by Purchasing)
[•]	[ ]	Memo addressed to City Manager (under 60K) Committees/City Council (over 60K)
[•]	[ ]	State Price Agreement
[ ]	[•]	RFP
[ ]	[•]	Evaluation Committee Report
[ ]	[•]	ITB
[ ]	[•]	Bib Tab
[ ]	[•]	Quotes (3 valid current quotes)
[ ]	[•]	Cooperative Agreement
[ ]	[•]	Sole Source Request and Determination Form
[ ]	[•]	Contractors Exempt Letter
[ ]	[•]	Purchasing Officers approval for exempt procurement
[ ]	[•]	BAR
[ ]	[•]	FIR
[•]	[ ]	Executed Contract, Agreement or Amendment
[•]	[ ]	Current Business Registration and CRS numbers on contract or agreement
[•]	[ ]	Summary of Contracts and Agreements form
[•]	[ ]	Certificate of Insurance
[•]	[ ]	All documentation presented to Committees
[ ]	[•]	Other:

Michelle A. Gurule	Contracts Administrator	11/07/22
Department Rep Printed Name (attesting that all information included)	Title	Date
	Contracts Supervisor	Nov 9, 2022
Purchasing Officer (attesting that all information is reviewed)	Title	Date
Manuel Gonzales (Nov 9, 2022 11:09 MST)	ITT Department Director	Nov 9, 2022
ITT Representative (attesting that all information is reviewed)	Title	Date

Include all other substantive documents and records of communication that pertain to the procurement and contract.

City of Santa Fe

Real Estate Summary of Contracts, Agreements, Amendments & Leases

Section to be completed by department

1. Munis Contract # 3201719

Contractor: Altura Communications Solutions

Description: ITT Phone Systems, 3 Year Term in the amount of $194,653.07 Per Year.

Contract ☐ Agreement ☐ Lease / Rent ☐ Amendment ☉

Term Start Date: 12/31/22 Term End Date: 12/31/25

☐ Approved by Council Date: _____

Contract / Lease:

Amendment # 1 to the Original Contract / Lease # 20-0041

Increase/(Decrease) Amount $ $583,959.21 for 3 Year Term - $194,653.07 Per Year

Extend Termination Date to: 12/31/25

☐ Approved by Council Date: _____

Amendment is for:

2. **HISTORY of Contract, Amendments & Lease / Rent - Please Elaborate** (option: attach spreadsheet if multiple amendments)

Original Contract was in Debember 2019 through SPA #70-361-17-02013AA Expires 04/30/24.
This amendment 1 is to increase the compensation and extend the term to December 2025.

3. **Procurement History:** SPA 70-61-17-02013AA Expires 04/30/24

Purchasing Officer Review: Nov 9, 2022 Date:

Comment & Exceptions: SWPA

4. **Funding Source:** ITT Enterprise Applications Services **Org / Object:** 6203600-530710

Andy Hopkins (Nov 7, 2022 11:01 MST)
Budget Officer Approval: Nov 7, 2022 Date:

Comment & Exceptions: _____

Staff Contact who completed this form: Michelle A. Gurule Phone # 505-955-5533

Email: magurule@santafenm.gov

To be recorded by City Clerk:
Clerk # _____
Date of Execution: _____

Manuel Gonzales (Nov 9, 2022 11:09 MST)
ITT Representative (attesting that all information is reviewed) | ITT Department Director (Title) | Nov 9, 2022 (Date)

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 07/01/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Melissa Brim	
Brown & Brown of Indiana, LLC	PHONE (A/C, No, Ext): (317) 574-5000	FAX (A/C, No): (317) 471-1700
11595 N Meridian St, Suite 250	E-MAIL ADDRESS: Melissa.Brim@bbrown.com	
Carmel IN 46032	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : The Continental Insurance Company	35289
INSURED	INSURER B : National Fire Insurance Company of Hartford	20478
WTI Holdings, LLC dba Waterfield Technologies	INSURER C : Federal Insurance Company	20281
One W. Third St., Ste. 1115	INSURER D : Beazley Insurance Company	38540
	INSURER E : Westchester Fire Insurance Company	10030
Tulsa OK 74103	INSURER F : Evanston Insurance Company	35378

COVERAGES **CERTIFICATE NUMBER:** 2022 Master Liability **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	☒ COMMERCIAL GENERAL LIABILITY ☐ CLAIMS-MADE ☒ OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: ☐ POLICY ☒ PRO-JECT ☐ LOC ☐ OTHER:	Y		7014687563	07/01/2022	07/01/2023	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 1,000,000 $ 15,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
B	AUTOMOBILE LIABILITY ☒ ANY AUTO ☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS ☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY			7014687577	07/01/2022	07/01/2023	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
A	☒ UMBRELLA LIAB ☒ OCCUR ☐ EXCESS LIAB ☐ CLAIMS-MADE ☐ DED ☒ RETENTION $ 10,000			7014687580	07/01/2022	07/01/2023	EACH OCCURRENCE AGGREGATE	$ 10,000,000 $ 10,000,000
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N / A					☐ PER STATUTE ☐ OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ $ $
C	Crime			82410006	07/01/2022	07/01/2023	Crime Limit Retention	$4,000,000 $15,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Complete Named Insured: WTI Holdings, LLC; Chrysalis Software, Inc. ; Waterfield Technologies Acquisition 2014-I, LLC; Waterfield Enterprises, LLC; Digital DataVoice Corporation; Blueworx; Affinity Financial Corp.; PDT Communications; AIC Holdco LLC; Altura Communications Solutions, LLC; Altura Intermediate Corporation

City of Santa Fe is included as an Additional Insured as respects to General Liability.

CERTIFICATE HOLDER

City of Santa Fe
200 Lincoln Avenue
Santa Fe NM 87501

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

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City of Santa Fe

Treasury Department
200 Lincoln Ave.
Santa Fe, New Mexico 87504-0909
505-955-6551

BUSINESS REGISTRATION

Business Name: ALTURA COMMUNICATION SOLUTIONS
DBA: ALTURA COMMUNICATION SOLUTIONS

Business Location: 2074 GALISTEO ST STE B5
SANTA FE, NM 87505

CRS Number: 02481372009

Owner: ALTURA COMMUNICATION SOLUTIONS

License Number: 227014

License Type: Business License - Renewable

Issued Date: December 07, 2021

Classification: Business Registration - Standard

Expiration Date: December 07, 2022

Fees Paid: $35.00

ALTURA COMMUNICATION SOLUTIONS
1540 S LEWIS ST
ANAHEIM, CA 64235

THIS IS NOT A CONSTRUCTION PERMIT OR SIGN PERMIT. APPROPRIATE PERMITS MUST BE OBTAINED FROM THE CITY OF SANTA FE BUILDING PERMIT DIVISION PRIOR TO COMMENCEMENT OF ANY CONSTRUCTION OR THE INSTALLATION OF ANY EXTERIOR SIGN.

THIS REGISTRATION/LICENSE IS NOT TRANSFERRABLE TO OTHER BUSINESSES OR PREMISES.

TO BE POSTED IN A CONSPICUOUS PLACE

Signature: Manuel Gonzales
Manuel Gonzales (Nov 7, 2022 10:08 MST)

Email: mmgonzales@ci.santa-fe.nm.us

GB_Altura Communications Solutions Agreement Packet

Final Audit Report 2022-11-07

Created:	2022-11-07
By:	Michelle Gurule (magurule@ci.santa-fe.nm.us)
Status:	Signed
Transaction ID:	CBJCHBCAABAA4U2eV1k8XpcUTqC3Vcwhz4uHDjyy_Fwd

"GB_Altura Communications Solutions Agreement Packet" History

Document created by Michelle Gurule (magurule@ci.santa-fe.nm.us)
2022-11-07 - 4:24:54 PM GMT- IP address: 63.232.20.2

Document emailed to mmgonzales@ci.santa-fe.nm.us for signature
2022-11-07 - 4:25:33 PM GMT

Email viewed by mmgonzales@ci.santa-fe.nm.us
2022-11-07 - 5:07:03 PM GMT- IP address: 104.47.65.254

Signer mmgonzales@ci.santa-fe.nm.us entered name at signing as Manuel Gonzales
2022-11-07 - 5:08:11 PM GMT- IP address: 174.205.44.77

Document e-signed by Manuel Gonzales (mmgonzales@ci.santa-fe.nm.us)
Signature Date: 2022-11-07 - 5:08:13 PM GMT - Time Source: server- IP address: 174.205.44.77

Agreement completed.
2022-11-07 - 5:08:13 PM GMT

City of Santa Fe, New Mexico
Memorandum

DATE: **October 19, 2022**

TO: **Governing Body**
Finance Committee
Quality of Life Committee

VIA: **John Blair, City Manager**
Emily Oster, Finance Department Director
Joann Lovato, Contracts Supervisor
Manuel Gonzales, ITT Department Director MG

FROM: **Michelle A. Gurule, Contracts Administrator** MG

ITEM AND ISSUE:
ITT Request for the Approval of Telecommunications Agreement in the Total Amount of $762.00 per month, $9,144.00 per year for sixty months for GEO MAX Services at 100 Water Street; (Century Link; (Manuel Gonzales, mmgonzales@santafenm.gov and telephone 505-955-5576)

BACKGROUND AND SUMMARY:

This amendment agreement provides for adding a network circuit the City's new Water Street facility. This circuit is part of the existing GEOMAX network that provides our city data networks and Internet services across CenturyLink's fiber network. The GEOMAX agreement provides up to 1 Gb for each fiber circuit attached City facility and networking security. The Water Street Facility has a new City building that has networking needs for staff, cameras, and public WiFi services.

PROCUREMENT METHOD:

The procurement method is the attached Memo Request for Exemption as per City of Santa Fe Ordinance Chapter 11-13-N(1)

CONTRACT NUMBER:
The FY23 Munis contract number is 3203690.

FUNDING SOURCE:

The funding source is:
Fund Name/Number: Services of Other Departments: 620
Munis Org Name/Number: ITT ISV: 6203650
Munis Object Name/Number: Communications: 514100

ACTION REQUESTED:
ITT respectfully requests your review and approval.

AMENDMENT NO. ONE
TO
INTRASTATE GEOMAX SERVICE CONTRACT DOCUMENT
ITEM#19-0871

THIS AMENDMENT NO. ONE ("Amendment") to the Intrastate GeoMax Agreement, Content ID: **CLM 1248485** by and between Qwest Corporation d/b/a CenturyLink QC ("CenturyLink") and **CITY OF SANTA FE** ("Customer") as may have been previously amended ("Agreement") is incorporated into the Agreement by this reference. Capitalized terms not defined in this Amendment are defined in the Agreement. The parties hereby agree to amend the Agreement dated 11/13/19 as follows:

1. Addition of Services. The Service set forth below ("New Service") is added to, and constitutes a part of, the Agreement and the existing Service. The New Service is coterminous with the existing Service and will terminate at the same time as the existing Service. The New Service is subject to all other terms and conditions of the Tariff and Agreement not expressly addressed in this Amendment. New rate elements cannot be added during the last 12 months of the Agreement. Customer agrees to pay all MRCs and NRCs related to the following additions. Sections containing "N/A" indicate that additions of that type are not included as part of this Amendment.

CAR L239157

Customer Interface:

Port Type/Name	Port Speed	No. of Ports	Unprotected/ Protected	MRC/each	NRC/each
Gigabit Ethernet	**1.25 Gbps**	**2**	**Unprotected**	**$330.00**	**$0.00**

Network Access Channel (NAC):

Quantity	CO Node Location	MRC/each	NRC/each
1	100 E Water St, Santa Fe, NM, 87501	**$102.00**	**$0.00**

Total MRC: $762.00 Yearly Total $9,144.00
Total NRC: $0.00
TOTAL for Sixty Months $45,720.00

2. Effective Date. This Amendment is effective when signed by CenturyLink ("Amendment Effective Date"). The terms and rates for the Service added pursuant to this Amendment are effective as of the Amendment Effective Date.

3. Miscellaneous. If Customer's Agreement does not contain the following language in the Payment section, then the language is hereby incorporated at the end of the Payment section: "Customer must not remit payment for the Services by funds obtained through the American Recovery and Reinvestment Act (or ARRA) or other similar stimulus grants or loans that would obligate CenturyLink to provide certain information or perform certain functions unless those functions and obligations are specifically included and agreed to by the parties elsewhere in this Agreement or in an amendment to this Agreement." All other terms and conditions in the Agreement will remain in full force and effect and be binding upon the parties. The Tariff, this Amendment, and the Agreement set forth the entire understanding between the parties as to the subject matter herein and supersede any prior written or verbal statements, representations, and agreements concerning the subject matter hereof. The order of control is: the Tariff, this Amendment, and the Agreement.

4. Notices. This notice language replaces the Agreement notice language if that language is different. All notices must be in writing. Notices are deemed given if sent to the addressee specified for a party either: (a) by registered or certified U.S. mail, return receipt requested, postage prepaid, three days after such mailing; or (b) by national overnight courier service, next business day; or (c) by facsimile when delivered if duplicate notice is also sent by regular U.S. Mail.

(a) Service Notices. All Customer notices for Service disconnect and termination must be sent via e-mail to: CenturyLink, Attn.: BusinessDisconnects@centurylink.com and must contain the account name, account number, identification of the Service(s), and Service address(es). Such disconnect and termination is effective 30 days after CenturyLink's receipt of the notice. All Customer notices for Service non-renewal and other routine operational notices will be provided to its CenturyLink sales representative. Failure to provide disconnect, termination and non-renewal notices in accordance with the terms of this Agreement may result in continued charges, and CenturyLink will not credit charges for such noncompliance.

(b) Legal Notice. All legal notices required to be given under the Agreement will be in writing and provided to CenturyLink at: 931 14th St., #900, Denver, CO 80202; Fax: 888-778-0054; Attn.: Legal Dept., and to Customer as provided in the Agreement or in its absence, to Customer's address reflected in CenturyLink's records Attn. General Counsel.

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AMENDMENT NO. ONE
TO
INTRASTATE GEOMAX SERVICE CONTRACT DOCUMENT
ITEM#19-0871

An authorized representative of each party has executed this Amendment as set forth below. Electronic signatures on this Amendment will be accepted only in the form and manner prescribed by CenturyLink.

QWEST CORPORATION D/B/A CENTURYLINK QC	**CITY OF SANTA FE**
Alex Khanin Alex Khanin (Oct 13, 2022 11:42 MDT)	
Authorized Signature	Authorized Signature
Alex Khanin	
Name Typed or Printed	Name Typed or Printed
Manager- Offer Management	
Title	Title
10/13/2022	
Date	Date

(FOR CENTURYLINK INTERNAL USE ONLY)
FUNDING CONCURRENCE REQUIRED PRIOR TO EXECUTION
AQCB Quote No. _____
Date Concurred:

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IN WITNESS WHEREOF, the Parties have executed this Agreement as of the date of the signature by the required approval authorities below.

CITY OF SANTA FE:

_____
ALAN WEBBER, CITY MAYOR

DATE:_____

CONTRACTOR:

__Please See Pg 2
NAME

_____
TITLE

DATE:_____
_ CRS#_____

Registration # _____

ATTEST:

_____
KRISTINE MIHELCIC, CITY CLERK

CITY ATTORNEY'S OFFICE:

Marcos Martinez
Marcos Martinez (Oct 18, 2022 13:10 MDT)

_____
SENIOR ASSISTANT CITY ATTORNEY

APPROVED FOR FINANCES:

_____
EMILY OSTER, FINANCE DIRECTOR

Org.Name/Org.# ITT INFRA Comm

6203650.514100 AH
AH

OMR #: R432778

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CENTURYLINK GEOMAX® SERVICE
Intrastate

ITEM # 19-0871

Agreement Number: _____
Billing Number: _____

This GeoMax Service ("Service") Agreement ("Agreement") is between Qwest Corporation d/b/a CenturyLink QC ("CenturyLink") and CITY OF SANTA FE ("Customer") and is effective on the date CenturyLink signs it ("Effective Date").

Tariff

Service will be governed by: (a) the Tariff applicable to Service; and (b) to the extent a comparable Tariff term or condition does not apply to Service, the terms and conditions set forth in this Agreement. "Tariff" includes as applicable: CenturyLink state tariffs, price lists, price schedules, administrative guidelines, catalogs, and rate and term schedules incorporated by this reference and posted at http://www.centurylink.com/tariffs. Service is subject to technical publication 77407 located at http://www.centurylink.com/techpub/ ("Tech Pub").

1. Scope.

1.1 CenturyLink will provide, and Customer will purchase, the Service provided under this Agreement. CenturyLink will provide Service up to the Standard Network Interface ("SNI") at Customer's premises. The SNI is that location where CenturyLink's protected network facilities end and Customer's inside wire or network begins, normally at a fiber distribution panel ("FDP").

1.2 Service is a robust, high speed, multi-protocol, fiber optic data transport service. It utilizes Dense Wave Division Multiplexing ("DWDM") technology enabling two or more optical signals having different wavelengths to be transmitted simultaneously in the same direction over one strand of fiber. Specific customer interfaces are listed in the Payment section.

1.3 To ensure diversity on "Protected Service," fiber optic paths will be separated by a minimum of 25 feet (where available) at all points to the last manhole. If one fiber optic path fails, Service will switch automatically to the other path within 50 milliseconds.

1.4 Customer understands and agrees that CenturyLink supplies Service as an intrastate, intraLATA telecommunications service, as defined by State and/or Federal Communications Commission ("F.C.C.") regulations, which are incorporated herein by this reference. It is Customer's responsibility to ensure that Customer uses Service as an intrastate, intraLATA telecommunications service consistent with such regulations. F.C.C. regulations permit interstate usage of Service if such usage does not exceed 10% of the total usage. If Customer should use this Service for any other purpose, or if interstate usage exceeds 10%, it is Customer's responsibility to immediately notify CenturyLink of such use and to place an order for appropriate service. CenturyLink will bill, and Customer will promptly pay, appropriate monthly recurring charges, for such use of and changes to Customer's telecommunications service including, but not limited to all applicable CenturyLink Rates and Services Schedule No. 1 interstate access charges or intrastate Tariff access charges.

1.5 "Construction" means when Service may not be available due to facilities limitations and it is necessary for CenturyLink to construct facilities. "Funding" means charges to Customer over the term of a Service contract covering CenturyLink's calculated costs for providing Service and it's expected rate of return when network infrastructure is not available to provide Service to Customer. CenturyLink may assess separate Construction charges if facilities are not available to meet an order for Service and CenturyLink constructs facilities under one or more of the following circumstances: (a) the amount of Customer's expected payments over the term of the Agreement does not exceed CenturyLink's calculated cost of providing the Service plus its expected rate of return; (b) Customer requests that Service be furnished using a type of facility, or via a route that CenturyLink would not normally utilize in providing the requested Service; (c) more facilities are requested than would normally be required to satisfy an order; and (d) Customer requests that Construction be expedited, resulting in added cost to CenturyLink. Service provided under this Agreement is subject to Funding approval and that approval will be evidenced in the Funding Concurrence block on this Agreement. That approval will be granted at the sole discretion of CenturyLink. In the event contract documents are signed under which Customer is ordering Service for which Funding is not approved, CenturyLink will cooperate with Customer in good faith to develop an alternative service solution if Funding cannot be achieved on the contracted solution and CenturyLink may immediately terminate this Agreement, without penalty, if Funding of the contracted and alternate Service solutions are determined to not be possible.

1.6 Filing Concurrence. CenturyLink may be required to submit an Agreement for a particular Service and any subsequent addenda for Service to certain regulatory agencies for approval because the rates in the Agreement are being offered on an individual case basis ("ICB"). Although the general terms and conditions of this Agreement are effective on the Effective Date, those service-specific rates, terms, and conditions that require filing with or approval by regulatory agencies ("ICB Terms") will not become effective for a given jurisdiction until the filing and approval requirements for that jurisdiction are fulfilled. Service will be offered in accordance with the applicable Tariff until the ICB Terms become effective. If Customer receives reduced pricing under the Agreement and a regulatory agency later invalidates the ICB Terms after they had become effective, Customer will pay to CenturyLink any difference in the amounts listed in the applicable Tariff for the Service and the amounts Customer was charged for the Service. When approved by the regulatory agencies, Customer may add additional quantities of Services pursuant to Section 9 under the same terms and conditions with no further filing required. In the event a regulatory agency does not approve the Agreement, the parties will enter into good faith negotiations to mutually resolve the failure to receive the necessary approval. The Agreement for a particular Service remains in full force and effect for Service in all other jurisdictions.

1.7 Service Level Agreement. The SLA provides Customer's sole and exclusive remedy for service interruptions or service deficiencies of any kind whatsoever for Service. "SLA" means the GeoMax service level agreement located at http://www.centurylink.com/legal/sla.html which is subject to change.

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1.8 Service/Maintenance. CenturyLink may from time to time suspend Service for routine maintenance or rearrangement of facilities or equipment. CenturyLink will give advance notification of any such suspension of Service. Such suspension of Service is not considered an out-of-service condition unless Service is not restored by the end of the period specified in the notification.

2. Term.

2.1 This Agreement is effective on the date on which it is executed by CenturyLink following Customer's execution of this Agreement ("Effective Date") and expires 48 months from the date Service requested under this Agreement is available to Customer, as evidenced by CenturyLink records ("Term"), consistent with NMSA 1978, sec. 13-1-150.

2.2 Both Parties agree to begin discussions regarding the renewal or discontinuation of this Agreement 90 days prior to its expiration. In the event negotiation cannot be met and CenturyLink continues to provide Service after the Term, Service will automatically revert to month-to-month rates. Month-to-month rates are only available upon completion of a fixed period service rate plan. Service provided on a month-to-month basis cannot be added to or changed. Month-to-month service may only be upgraded to a fixed period service rate plan of 36- or 60-months, or disconnected.

3. Charges and Billing.

3.1 Customer must pay CenturyLink all charges by the payment due date on the invoice. Any amount not paid when due is subject to late interest specified by the Tariff, or if there is no such late interest specified in the Tariff, the amount due will be subject to late interest at the lesser of 1.5% per month or the maximum rate allowed by law. In addition to payment of charges for Service, Customer must also pay CenturyLink any applicable Taxes assessed in connection with Service. "Taxes" means federal, state, and local excise, gross receipts, sales, use, privilege, or other tax (other than net income) now or in the future imposed by any governmental entity (whether such Taxes are assessed by a governmental authority directly upon CenturyLink or Customer) attributable or measured by the sale price or transaction amount, or surcharges, fees, and other similar charges that are required or permitted to be assessed on Customer. These charges may include state and federal Carrier Universal Service Charges, as well as charges related to E911, and Telephone Relay Service. Taxes may vary and are subject to change. Customer may access its invoices and choose paperless invoices online through CenturyLink Control Center located at controlcenter.centurylink.com. If Customer does not choose paperless invoices through Control Center, CenturyLink may in its discretion assess a $15 MRC for each full paper invoice provided to Customer or a $2 MRC for each summary/remit only (where available) paper invoice provided to Customer. Those charges will not apply to an invoice that is not available through Control Center. Customer's payments to CenturyLink must be in the form of electronic funds transfer (via wire transfer or ACH), cash payments (via previously-approved CenturyLink processes only), or paper check. CenturyLink reserves the right to charge administrative fees when Customer's payment preferences deviate from CenturyLink's standard practices.

3.2 Service's Monthly Recurring Charge ("MRC") and Nonrecurring Charges ("NRC") will be those stated in the Tariff on: (a) the date of installation for new Service; or (b) the Effective Date for existing Service. CenturyLink will protect the MRC from any CenturyLink-initiated price increases during the Term. Any rate increases directed or mandated by a regulatory body with proper authority will increase the MRCs and/or NRCs pursuant to the applicable order. Customer agrees to pay the charges for Service as specified in this Agreement. Customer's payment obligations are not contingent upon Customer's ability to collect payments or charges from any third party.

3.3 Order Acceptance and Cancellation. CenturyLink and Customer will determine a mutually agreeable date for Service to be available for use. Customer's acceptance of Service will be subject to the terms in the applicable Tariff. If the order for Service is canceled (a) at Customer's request; or (b) by CenturyLink due to Customer's failure to accept Service, Customer will be subject to cancellation charges in the applicable Tariff.

3.4 Customer hereby orders and agrees to pay the following charges for Service as shown below:

Customer Interface:

Port Type/Name	Port Speed	No. of Ports	Unprotected/Protected	MRC/each	NRC/each
Gigabit Ethernet	1.25 Gbps	68	Unprotected	$330.00	$0.00
			Monthly Total	**$22,440.00**	
			12 Month Total	**$269,280.00**	
			48 Month Total	**$1,077,120.00**	

Network Access Channel (NAC):

Quantity (34)	CO Node Location	MRC/each	NRC/each
1	2515 Camino Entrada Santa Fe, NM 87507	$102.00	$0.00
1	6599 Jaguar Dr Santa Fe, NM 87507	$102.00	$0.00
1	6796 Jaguar Dr Santa Fe, NM 87507	$102.00	$0.00
1	801 W San Mateo Rd Santa Fe, NM 87505	$102.00	$0.00

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1	490 Bishops Lodge Rd Santa Fe, NM 87501	$102.00	$0.00
1	1730 Llano St Santa Fe, NM 87505	$102.00	$0.00
1	35 Camino Justicia Santa Fe, NM 87508	$102.00	$0.00
1	301 Montezuma Ave Santa Fe, NM 87501	$102.00	$0.00
1	1751 Cerrillos Rd Santa Fe, NM 87505	$102.00	$0.00
1	737 Agua Fria St Santa Fe, NM 87501	$102.00	$0.00
1	2651 Siringo Rd Santa Fe, NM 87505	$102.00	$0.00
1	1030 W Alameda St Santa Fe, NM 87501	$102.00	$0.00
1	1121 Alto St Santa Fe, NM 87501	$102.00	$0.00
1	1142 Siler Rd Santa Fe, NM 87507	$102.00	$0.00
1	2391 Richards Ave Santa Fe, NM 87507	$102.00	$0.00
1	2931 Rufina St Santa Fe, NM 87507	$102.00	$0.00
1	500 Market St Santa Fe, NM 87501	$102.00	$0.00
1	1130 Arroyo Chamiso Rd Santa Fe, NM 87505	$102.00	$0.00
1	2511 Camino Entrada Santa Fe, NM 87507	$102.00	$0.00
1	601 Alta Vista St Santa Fe, NM 87505	$102.00	$0.00
1	216 W San Francisco St Santa Fe, NM 87501	$102.00	$0.00
1	3221 Rodeo Rd Santa Fe, NM 87507	$102.00	$0.00
1	205 Caja Del Rio Rd, Santa Fe, NM 87507	$102.00	$0.00
1	73 Paseo Real Santa Fe, NM 87507	$102.00	$0.00
1	6601 Valentine Way Santa Fe, NM 87507	$102.00	$0.00
1	100 Caja Del Rio Rd Santa Fe, NM 87507	$102.00	$0.00
1	121 Aviation Dr Santa Fe, NM 87507	$102.00	$0.00
1	145 Washington Ave Santa Fe, NM 87501	$102.00	$0.00
1	715 Alta Vista St Santa Fe, NM 87505	$102.00	$0.00
1	1600 St Michaels Dr Santa Fe, NM 87505	$102.00	$0.00
1	200 Lincoln Ave Santa Fe, NM 87501	$102.00	$0.00
1	341 CAJA DEL RIO RD, SANTA FE, NM 87506	$102.00	$0.00
1	66 E SAN FRANCISCO ST, SANTA FE, NM, 87501	$102.00	$0.00
1	200 MURALES RD, SANTA FE, NM, 87501-1173	$102.00	$0.00
	1 Month Total	**$3,468.00**	
	12 Month Total	**$41,616.00**	
	48 Month Total	**$166,464.00**	

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v1.022119

Nodes (includes first shelf in each node):

Node Type (Premise of CO)	Quantity	Location	MRC/each
Premise	1	715 ALTA VISTA ST, SANTA FE, NM, 87505	$2,188.80
CO	1	121 E ALAMEDA ST, SANTA FE, NM, 87501	$1,732.80
CO	1	1117 CALLE LA RESOLANA, SANTA FE, NM, 87507	$1,732.80
		1 Month Total	**$5,654.40**
		12 Month Total	**$67,852.80**
		48 Month Total	**$271,411.20**

4. Customer Responsibilities. Customer is responsible for the following:

4.1 Environmental Requirements. Customer will ensure that the environment at Customer's premises in which CenturyLink equipment will reside meets all applicable local, state, and/or national safety codes. Customer is required to provide adequate building space, lighting, and atmospheric control (humidity, temperature, and ventilation) for the proper installation, operation, and maintenance of CenturyLink equipment and facilities on the Customer premises. Customer will provide written notice to CenturyLink of any health or safety hazards known by Customer to exist arising from or related to Customer's operations to which CenturyLink employees may be exposed while working at Customer premises and any required control measures necessary to prevent hazardous exposures to CenturyLink employees.

4.2 Power Requirements. Customer will provide the appropriate alternating current ("AC") power supply as specified by CenturyLink based on the customer specific network design for normal operations of CenturyLink electronic equipment. All power supply sources will comply with national standards and safety codes. Customer should also extend a suitable ground source to the telecommunications equipment area. In the event a Service outage(s) occurs due to AC power failure, and backup power is provided by Customer (not CenturyLink), and such backup power also fails, CenturyLink will be exempt from meeting the specified SLAs for such Service outage(s).

4.3 Access. Customer will provide prompt access to its premises to CenturyLink authorized personnel or other authorized parties, responding to Service restoration, equipment failure, maintenance, or other relevant situations, and such access to CenturyLink equipment will be available 24 hours a day, 365 days a year.

4.4 On-Site Operations. All Customer operations concerning Service at Customer's premises will be performed at the expense of Customer, and Customer will be required to conform to all applicable specifications that CenturyLink may adopt as necessary to maintain Service. Any special structural work required for supporting telecommunications facilities needed in order to provide Service on Customer's premises will be provided at the expense of Customer.

5. Optional Performance Monitoring.

5.1 CenturyLink will monitor and manage the Service 24 hours a day, 365 days a year.

5.2 Customer will provide, at Customer's own expense, a terminal compatible with the CenturyLink equipment used to provision Service to allow read-only monitoring of the Service.

6. Equipment and Installation.

6.1 CenturyLink will provide, install, maintain, repair, operate, and have sole access to the equipment necessary for Service. CenturyLink will pay the cost of purchasing and installing all fiber and equipment necessary for Service; however, any special construction for additional fiber that is nonreusable or nonrecoverable (as determined by CenturyLink) will be at an additional charge to Customer. Customer will be notified in writing of any such charges prior to execution of this Agreement.

6.2 CenturyLink will procure and maintain at CenturyLink's expense, all rights-of-way and private or public easements or licenses required for the installation of CenturyLink's equipment and fiber.

6.3 The fiber and equipment will remain the sole and exclusive property of CenturyLink or its assignee, and nothing contained herein will give or convey to Customer any right, title, or interest whatsoever in such fiber and equipment, except as otherwise provided herein. Such fiber and equipment is and will remain personal property, notwithstanding that it may be, or become, attached to or embedded in realty.

7. Service Changes.

7.1 Additions and/or changes to Service elements at the specified locations may be added at existing agreement rates through and including the 24th month of this Agreement, and such additions and/or changes will be subject to all terms of this Agreement, including the Term. Additions and/or changes to Service will be handled by written amendment mutually agreed upon by the Parties, some elements of

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Service may not be changeable, CenturyLink has the right to not change certain elements of Service. New rate elements cannot be added during the last 12 months of this Agreement. Customer agrees to pay all MRCs and NRCs related to the changes.

7.2 In the event Customer requests additional Service with fewer than 12 months remaining in the Term, Customer will be required to enter into a separate agreement.

7.3 Customer may move or add to the Service ("Change") if CenturyLink commercially offers the Change to the Service, and Customer agrees to pay all applicable charges related to the Change, including all then-current MRCs and NRCs and any excess construction charges.

8. Termination.

8.1 Either party may terminate Service and/or this Agreement in accordance with the applicable Tariff or for Cause. "Cause" means the failure of a party to perform a material obligation under this Agreement, which failure is not remedied: (a) for payment defaults by Customer, within five days of separate written notice from CenturyLink of such default (unless a different notice period is specified in the Tariff); or (b) for any other material breach, within 30 days of written notice (unless a different notice period is specified in the Tariff or this Agreement). Customer will remain liable for charges accrued but unpaid as of the termination date. Prior to the conclusion of the Term, if Service and/or this Agreement is terminated either by CenturyLink for Cause or by Customer for any reason other than Cause, then Customer will also be liable for a termination charge "Termination Charge" of:

(a) If during the first 12 months of Service ("Minimum Service Period"), Customer will pay all accrued and unpaid charges for Service provided through the effective date of such termination plus a Termination Charge of 100% of the MRCs for the terminated Service (or any fraction thereof), multiplied by the number of months, or portion thereof, remaining in the Minimum Service Period, plus 70% of the MRCs for the terminated Service (or any fraction thereof), multiplied by the number of months after the Minimum Service Period remaining in the Initial Term.

(b) If after the Minimum Service Period, Customer will pay for all accrued and unpaid charges for Services provided through the effective date of such termination plus a Termination Charge of 70% of the MRCs for the terminated Service (or any fraction thereof), multiplied by the number of months, or portion thereof, remaining in the Initial Term.

8.3 CenturyLink may: (a) immediately suspend all or any part of the Service; and/or (b) terminate this Agreement (effective after the applicable notice period): (i) for Cause (as defined herein); or (ii) upon written notice if Customer becomes or is declared insolvent or bankrupt or is the subject of any proceedings related to its liquidation, insolvency or for the appointment of a receiver or similar officer for it.

9. Confidentiality. Neither party will, without the prior written consent of the other party: (a) disclose any of the terms of this Agreement; or (b) disclose or use (except as expressly permitted by, or required to achieve the purposes of, this Agreement) the Confidential Information of the other party. "Confidential Information" means any information that is not generally available to the public, whether of a technical, business, or other nature, and that: (a) the receiving party knows or has reason to know is confidential, proprietary, or trade secret information of the disclosing party; or (b) is of such a nature that the receiving party should reasonably understand that the disclosing party desires to protect the information from disclosure. Confidential Information will not include information that is in the public domain through no breach of this Agreement by the receiving party or is already known or is independently developed by the receiving party. Each party will use reasonable efforts to protect the other's Confidential Information, and will use at least the same efforts to protect such Confidential Information as the party would use to protect its own. CenturyLink's consent may only be given by its Legal Department. A party may disclose Confidential Information if required to do so by a governmental agency, by operation of law, or if necessary in any proceeding to establish rights or obligations under this Agreement.

10. Use of Name and Marks. Neither party will use the name or marks of the other party or any of its Affiliates for any purpose without the other party's prior written consent. CenturyLink's consent may only be given by its Legal Department. "Affiliate" means any entity controlled by, controlling, or under common control with a party

11. Disclaimer of Warranties. EXCEPT AS EXPRESSLY PROVIDED IN THIS AGREEMENT, SERVICE IS PROVIDED "AS IS." CENTURYLINK DISCLAIMS ALL EXPRESS OR IMPLIED WARRANTIES, INCLUDING BUT NOT LIMITED TO ALL WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, AND NON-INFRINGEMENT.

12. Limitations of Liability. The remedies and limitations of liability for any claims arising between the parties are set forth below.

12.1 Consequential Damages. NEITHER PARTY OR ITS AFFILIATES, AGENTS, OR CONTRACTORS IS LIABLE FOR ANY CONSEQUENTIAL, INCIDENTAL, INDIRECT, SPECIAL, OR PUNITIVE DAMAGES OR FOR ANY LOST PROFITS, LOST REVENUES, LOST DATA, LOST BUSINESS OPPORTUNITY, OR COSTS OF COVER. THESE LIMITATIONS APPLY REGARDLESS OF THE LEGAL THEORY UNDER WHICH SUCH LIABILITY IS ASSERTED AND REGARDLESS OF FORESEEABILITY.

12.2 Claims Related to Service. For Service related claims by Customer, Customer's exclusive remedies are limited to the applicable out-of-service credits, if any.

12.3 Personal Injury; Death; Property Damages. For claims arising out of personal injury or death to a party's employee, or damage to a party's real or personal property, that are caused by the other party's negligence or willful misconduct in the performance of this Agreement, each party's liability is limited to proven direct damages.

13. Miscellaneous.

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13.1 General. This Agreement's benefits do not extend to any third party (e.g., an End User). "End User" means Customer's members, end users, customers, or any other third parties who use or access Service or the CenturyLink network via Service. If any term of this Agreement is held unenforceable, the remaining terms will remain in effect. Neither party's failure to exercise any right or to insist upon strict performance of any provision of this Agreement is a waiver of any right under this Agreement. The terms and conditions of this Agreement regarding confidentiality, limitation of liability, warranties, payment, dispute resolution, and all other terms of this Agreement that should by their nature survive the termination of this Agreement will survive. Each party is not responsible for any delay or other failure to perform due to a Force Majeure Event. "Force Majeure Event" means an unforeseeable event beyond the reasonable control of that party, including without limitation: act of God, fire, explosion, lightning, hurricane, labor dispute, cable cuts by third parties, acts of terror, material shortages or unavailability, government laws or regulations, war or civil disorder, or failures of suppliers of goods and services. Customer may not assign this Agreement or any of its rights or obligations under this Agreement without the prior written consent of CenturyLink, which consent will not be unreasonably withheld. Customer may not assign to a reseller or a telecommunications carrier under any circumstances and Customer represents that it will not resell Service.

13.2 Conflicts Provision. If a conflict exists among provisions within this Agreement, the following order of precedence will apply in descending order of control: Tariff, this Agreement, the Tech Pub and CenturyLink records.

13.3 Independent Contractor. CenturyLink provides Service as an independent contractor. This Agreement will not create an employer-employee relationship, association, joint venture, partnership, or other form of legal entity or business enterprise between the parties, their agents, employees or affiliates.

13.4 ARRA. Customer will not pay for Service with funds obtained through the American Recovery and Reinvestment Act or other similar stimulus grants or loans that would obligate CenturyLink to provide certain information or perform certain functions unless each of those obligations are explicitly identified and agreed to by the parties in this Agreement or in an amendment to this Agreement.

13.5 HIPAA. CenturyLink Communications, LLC does not require or intend to access Customer data in its performance hereunder, including but not limited to any confidential health related information of Customer's clients, which may include group health plans, that constitutes Protected Health Information ("PHI"), as defined in 45 C.F.R. §160.103 under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Rules"). To the extent that any exposure to PHI is incidental to CenturyLink's provision of Service and not meant for the purpose of accessing, managing the PHI or creating or manipulating the PHI, such exposure is allowable under 45 CFR 164.502(a)(1)(iii).

13.6 Credit Approval. Provision of Service is subject to CenturyLink's credit approval of Customer. As part of the credit approval process, CenturyLink may require Customer to provide a deposit or other security. Additionally during the Term, if Customer's financial circumstance or payment history becomes reasonably unacceptable to CenturyLink, CenturyLink may require adequate assurance of future payment as a condition of continuing CenturyLink's provision of Service. Customer's failure to provide adequate assurances required by CenturyLink is a material breach of this Agreement. CenturyLink may provide Customer's payment history or other billing/charge information to credit reporting agencies or industry clearinghouses.

13.7 Governing Law; Dispute Resolution.

(a) Governing Law; Forum. New Mexico state law, without regard to choice-of-law principles, governs all matters relating to this Agreement, except with regard to matters which are within the exclusive jurisdiction of the state or federal regulatory agency. Any legal proceeding relating to this Agreement will be brought in a U.S. District Court, or absent federal jurisdiction, in a state court of competent jurisdiction, in Santa Fe, New Mexico. This provision is not intended to deprive a small claims court or state agency of lawful jurisdiction that would otherwise exist over a claim or controversy between the parties. Each party will comply with all applicable laws, rules and regulations associated respectively with CenturyLink's delivery or Customer's use of the Service under the Agreement.

(b) Limitations Period. Any claim relating to this Agreement must be brought within two years after the claim arises.

13.8 No Resale; Compliance. Customer represents that it is not a reseller of any telecommunication services provided under this Agreement as described in the Telecommunications Act of 1996, as amended, or applicable state law and acknowledges it is not entitled to any reseller discounts under any laws. Customer's use of Service must comply with all applicable laws.

13.9 Amendments; Changes. This Agreement may be amended only in a writing signed by both parties' authorized representatives. Each party may, at any time, reject any handwritten change or other alteration to this Agreement. Centuryl ink may amend, change, or withdraw the Tariffs, with such updated Tariffs effective upon posting or upon fulfillment of any necessary regulatory requirements.

13.10 Notices. All notices must be in writing. Notices are deemed given if sent to the addressee specified for a party either: (a) by registered or certified U.S. mail, return receipt requested, postage prepaid, three days after such mailing; or (b) by national overnight courier service, next business day; or (c) by facsimile when delivered if duplicate notice is also sent by regular U.S. Mail.

(a) Service Notices. All Customer notices for Service disconnect and termination must be sent via e mail to: CenturyLink, Attn.: BusinessDisconnects@centurylink.com and must contain the account name, account number, identification of the Service(s), and Service address(es). Such disconnect and termination is effective 30 days after CenturyLink's receipt of the notice. All Customer notices for Service non-renewal and other routine operational notices will be provided to its CenturyLink sales representative. Failure to provide disconnect, termination and non-renewal notices in accordance with the terms of this Agreement may result in continued charges, and CenturyLink will not credit charges for such noncompliance.

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(b) Legal Notice. All legal notices required to be given under the Agreement will be in writing and provided to CenturyLink at: 931 14th St., #900, Denver, CO 80202; Fax: 888-778-0054; Attn.: Legal Dept., and to Customer as provided in the Agreement or in its absence, to Customer's address reflected in CenturyLink's records Attn. General Counsel.

13.11 Termination

This Agreement may be terminated by the Customer upon 60 days written notice to CenturyLink.

13.12 Indemnification

CenturyLink shall indemnify, hold harmless and defend the Customer from all losses, damages, claims or judgments, including payments of all attorneys' fees and costs on account of any suit, judgment, execution, claim, action or demand whatsoever arising from CenturyLink's performance under this Agreement as well as the performance of CenturyLink's employees, agents, representatives and subcontractors.

13.13 New Mexico Tort Claims Act

Any liability incurred by the Customer in connection with this Agreement is subject to the immunities and limitations of the New Mexico Tort Claims Act, Section 41-4-1, et. seq. NMSA 1978, as amended. The Customer and its "public employees" as defined in the New Mexico Tort Claims Act, do not waive sovereign immunity, do not waive any defense and do not waive any limitation of liability they may have pursuant to applicable law.

13.14 Non-Appropriations. Customer intends to continue this Agreement for its entire Term and to satisfy its obligations hereunder. For each fiscal period for Customer: (a) Customer agrees to include in its budget request appropriations sufficient to cover Customer's obligations under this Agreement; (b) Customer agrees to use all reasonable and lawful means to secure these appropriations; (c) Customer agrees it will not use non-appropriations as a means of terminating this Agreement in order to acquire functionally equivalent products or services from a third party. Customer reasonably believes that sufficient funds to discharge its obligations can and will lawfully be appropriated and made available for this purpose. In the event that Customer is appropriated insufficient funds, by appropriation, appropriation limitation or grant, to continue payments under this Agreement and has no other funding source lawfully available to it for such purpose (as evidenced by notarized documents provided by Customer and agreed to by CenturyLink), Customer may terminate this Agreement without incurring any termination charges by giving CenturyLink not less than 30 days' prior written notice. Upon termination and to the extent of lawfully available funds, Customer will remit all amounts due and all costs reasonably incurred by CenturyLink through the date of termination.

13.15 Third Party Beneficiaries

By entering into this Agreement, the parties do not intend to create any right, title or interest in or for the benefit of any person other than the Customer and CenturyLink. No person shall claim any right, title or interest under this Agreement or seek to enforce this Agreement as a third party beneficiary of this Agreement.

13.19 Insurance

A. CenturyLink, at its own cost and expense, shall carry and maintain in full force and effect during the term of this Agreement, comprehensive general liability insurance covering bodily injury and property damage liability, in a commercially available form and with an insurance company with minimum AM Best's rating of A-VII, with limits of coverage in the maximum amount which the Customer could be held liable under the New Mexico Tort Claims Act for each person injured and for each accident resulting in damage to property. Such insurance shall provide that the Customer is included as an additional insured. The Customer will be notified by CenturyLink no less than 30 days in advance of cancellation for any reason. CenturyLink shall furnish the Customer with a copy of a Certificate of Insurance as a condition prior to performing services under this Agreement.

B. CenturyLink shall also obtain and maintain Workers' Compensation insurance, required by law, to provide coverage for CenturyLink's employees throughout the term of this Agreement. CenturyLink shall provide the Customer with evidence of its compliance with such requirement.

C. CenturyLink shall maintain professional liability insurance throughout the term of this Agreement providing a minimum coverage in the amount required under the New Mexico Tort Claims Act. CenturyLink shall furnish the Customer with proof of insurance of CenturyLink's compliance with the provisions of this section as a condition prior to performing services under this Agreement.

13.20 Records and Audit

CenturyLink shall maintain reasonably comprehensive books and records of the Services performed to the extent necessary to substantiate the fees charged to Customer under the Agreement. Such books and records will be retained by CenturyLink for a period of at least two (2) years, or longer if required by applicable law, from and after the completion of such Services. Once each calendar year, upon at least thirty (30) days written notice from Customer, CenturyLink shall provide Customer and Customer's agents (including any third party auditor(s) designated by Customer) which have entered into a mutually agreeable non-disclosure agreement and agree to comply with rules for the facility, which will be provided to Customer or its auditor(s) as applicable in advance, at Customer's expense, with access during normal business days and hours to such books and records and documentation which support charges billed to Customer as may be reasonably requested by Customer that cover any period not to exceed 2 years from the date of the audit to determine that fees charged are accurate and in accordance with the Agreement.

13.24 Severability

In case any one or more of the provisions contained in this Agreement or any application thereof shall be invalid, illegal or unenforceable in any respect, the validity, legality, and enforceability of the remaining provisions contained herein and any other application thereof shall not in any way be affected or impaired thereby.

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13.25 Entire Agreement. This Agreement (including all referenced documents) constitutes the entire agreement between the parties and supersedes all prior oral or written agreements or understandings relating to the same service or circuits at the same locations as covered under this Agreement. Using CenturyLink's electronic signature process for this Agreement is acceptable.

QWEST CORPORATION D/B/A CENTURYLINK QC

Dan Sullivan
Authorized Signature

Dan Sullivan on behalf of Susan Baker
Name Typed or Printed

Lead SLED Relationship Manager
Title

8-14-2019
Date

CITY OF SANTA FE

Authorized Signature

Alan Webber
Name Typed or Printed

Mayor
Title

11/20/19
Date

Customer's Address for Notice:
Customer's facsimile number (if applicable):
Person designated for notices:

FOR CENTURYLINK INTERNAL USE ONLY
FUNDING CONCURRENCE REQUIRED PRIOR TO EXECUTION FOR NEW SERVICE (NOT REQUIRED FOR RENEWALS)
AQCB Quote No.
Date Concurred:

IN WITNESS WHEREOF, the parties have executed this Agreement on the date set forth below.

ATTEST:

Yolanda Y. Vigil
YOLANDA Y. VIGIL CCntg 11/13/19
CITY CLERK

APPROVED AS TO FORM:

MDM 8/15/19
ERIN MCSHERRY, CITY ATTORNEY
APPROVED:

Mary McCoy
MARY MCCOY, FINANCE DIRECTOR MM
620 3650.514100

~~Business Unit Line Item~~

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City of Santa Fe, New Mexico

memo

DATE: October 19, 2022

TO: Joann Lovato, Contracts Supervisor

FROM: Michelle A. Gurule, Contract Administrator MG

SUMMARY: Request for Exemption as Pursuant to City of Santa Fe Procurement Manual Section VI. Item #4.

Summary: The City of Santa Fe ITT division is requesting approval of use of exemption in the City of Santa Fe Procurement Manual Section VI Item #4.

Section VI. Exemptions from the Procurement Code All purchases are subject to the City's Procurement Manual with the exception of the items and services listed below.

Item #4 Purchases of publicly provided or publicly regulated gas, electricity, water, sewer, telecommunication, cable television and refuse collection services.

Procurement: Request for Exemption

Action: Please approve this request for an exemption pertaining to Contract #3203690

Budget: The cost is a onetime fee budgeted 6203650-514100

Contract Number: Munis Number 3203690

JoAnn Lovato
JoAnn Lovato (Oct 26, 2022 10:30 MDT)

Joann Lovato, Contracts Supervisor

CITY OF SANTA FE PROCUREMENT CHECKLIST

Contractor Name: Century Link

Procurement Title: Attached Memo Request for Exemption Per Santa Fe Ordinance 11-13-B(1)

Procurement Method: State Price Agreement ☐ Cooperative ☐ Sole Source ☐ Other ☐

Exempt ☑ Request For Proposal (RFP) ☐ Invitation To Bid (ITB) ☐ Contract under 60K ☐ Contract over 60K ☐

Department Requesting ITT Staff Name Michelle A. Gurule

Procurement Requirements:

A procurement file shall be maintained for all contracts, regardless of the method of procurement. The procurement file shall contain the basis on which the award is made, all submitted bids, all evaluation materials, score sheets, quotations and all other documentation related to or prepared in conjunction with evaluation, negotiation, and the award process. The procurement shall contain a written determination from the Requesting Department, signed by the purchasing officer, setting forth the reasoning for the contract award decision before submitting to the Committees.

REQUIRED DOCUMENTS FOR APPROVAL BY PURCHASING*

YES	N/A	
☑	☐	Approved Procurement Checklist (by Purchasing)
☑	☐	Memo addressed to City Manager (under 60K) Committees/City Council (over 60K)
☐	☑	State Price Agreement
☐	☑	RFP
☐	☑	Evaluation Committee Report
☐	☑	ITB
☐	☑	Bib Tab
☐	☑	Quotes (3 valid current quotes)
☐	☑	Cooperative Agreement
☐	☑	Sole Source Request and Determination Form
☐	☑	Contractors Exempt Letter
☑	☐	Purchasing Officers approval for exempt procurement
☐	☑	BAR
☐	☑	FIR
☑	☐	Executed Contract, Agreement or Amendment
☑	☐	Current Business Registration and CRS numbers on contract or agreement
☑	☐	Summary of Contracts and Agreements form
☑	☐	Certificate of Insurance
☑	☐	All documentation presented to Committees
☑	☐	Other:

Michelle A. Gurule Contracts Administrator 10/24/22

Department Rep Printed Name (attesting that all information included) Title Date

JoAnn Lovato
JoAnn Lovato (Oct 26, 2022 10:30 MDT)

Contracts Supervisor Oct 26, 2022

Purchasing Officer (attesting that all information is reviewed) Title Date

Manuel Gonzales ITT Department Director 10/24/22

ITT Representative (attesting that all information is reviewed) Title Date

Include all other substantive documents and records of communication that pertain to the procurement and contract.

City of Santa Fe

Real Estate Summary of Contracts, Agreements, Amendments & Leases

Section to be completed by department

1. Munis Contract # 3203690

Contractor: Century Link

Description: The ITT Department is requesting approval of the attached amendment to the Century Link GEOMAX Service agreement. This amendment agreement provides for adding a network circuit to the City's new Water Street facility.

Contract ☐ Agreement ☐ Lease / Rent ☐ Amendment ☉

Term Start Date: 12/01/22 Term End Date: 12/01/27

☐ Approved by Council Date: _____

Contract / Lease:

Amendment # 1 to the Original Contract / Lease # 19-0871

Increase/(Decrease) Amount $ $45,7520.00

Extend Termination Date to: 12/01/27

☐ Approved by Council Date: _____

Amendment is for:

2. **HISTORY** of Contract, Amendments & Lease / Rent - **Please Elaborate** (option: attach spreadsheet if multiple amendments)

3. **Procurement History:** Request for Exemption Per City of Santa Fe Ordinance Chapter 11-13-B(1)

JoAnn Lovato
JoAnn Lovato (Oct 26, 2022 10:30 MDT)

Purchasing Officer Review: Oct 26, 2022 Date:

Comment & Exceptions: Exempt Procurment

4. **Funding Source:** ITT ISV Communications **Org / Object:** 6203650-514100

Andy Hopkins
Andy Hopkins (Oct 25, 2022 16:44 MDT)

Budget Officer Approval: Oct 25, 2022 Date:

Comment & Exceptions: _____

Staff Contact who completed this form: Michelle A. Gurule Phone # 505-955-5533

Email: magurule@santafenm.gov

To be recorded by City Clerk:

Clerk # _____

Date of Execution: _____

Michelle Gurule — Contracts Supervisor — 10/24/22

ITT Representative (attesting that all information is reviewed) Title Date

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/13/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Marsh USA Inc.
CA License #0437153
1301 5th Avenue, Suite 1900
Seattle, WA 98101-2682
Attn: Seattle.certrequest@marsh.com / Fax: 212-948-4326
CN102197661-STND-ALL-22-23 091123

CONTACT NAME: ...
PHONE (A/C, No, Ext): **FAX (A/C, No):**
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Greenwich Insurance Company	22322
INSURER B : XL Specialty Insurance Co.	37885
INSURER C : Allianz Underwriters Ins Co	36420
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Lumen Technologies, Inc.
and all subsidiaries, including but not limited to:
Qwest Corporation; Embarq Corporation; Level 3 Communications, LLC and CenturyLink Communications, LLC
100 CenturyLink Dr.
Monroe, LA 71203

COVERAGES **CERTIFICATE NUMBER:** SEA-003574399-25 **REVISION NUMBER:** 2

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS		
A	X **COMMERCIAL GENERAL LIABILITY** [ ] CLAIMS-MADE [X] OCCUR X CONTRACTUAL LIABILITY GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY [ ] PRO-JECT [ ] LOC [ ] OTHER:			RGD500033310	09/01/2022	09/01/2023	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ $ $ $ $ $	3,000,000 500,000 10,000 3,000,000 15,000,000 15,000,000
A	**AUTOMOBILE LIABILITY** X ANY AUTO X OWNED AUTOS ONLY [ ] SCHEDULED AUTOS X HIRED AUTOS ONLY [X] NON-OWNED AUTOS ONLY			RAD500033410 Auto Physical Damage - Self Insured	09/01/2022	09/01/2023	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $ $ $	2,000,000
C	X **UMBRELLA LIAB** [X] OCCUR **EXCESS LIAB** [ ] CLAIMS-MADE [ ] DED [ ] RETENTION $			U5Z000023220	09/01/2022	09/01/2023	EACH OCCURRENCE AGGREGATE	$ $	10,000,000 10,000,000
B B B B	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	Y / N: N	N / A	RWD500032910 (AOS) RWR500033010 (WI) RWE500033110 (WA) RWE500033210 (OH)	09/01/2022 09/01/2022 09/01/2022 09/01/2022	09/01/2023 09/01/2023 09/01/2023 09/01/2023	X PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ $ $	 1,000,000 1,000,000 1,000,000
C	Technology E&O incl. Cyber/Privacy Liability			U5Z000022330	09/01/2022	09/01/2023	Each Claim/Aggregate Retention		10,000,000 5,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Start Date: 09/11/2018
End Date: 09/11/2023

CERTIFICATE HOLDER

City of Santa Fe
Attn: Larry Worstell
200 Lincoln Ave
Santa Fe, NM 87501

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE of Marsh USA Inc

Kathleen J. Stephens

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ACORD®

ADDITIONAL REMARKS SCHEDULE

AGENCY	NAMED INSURED
Marsh USA Inc.	Lumen Technologies, Inc. and all subsidiaries, including but not limited to: Qwest Corporation; Embarq Corporation; Level 3 Communications, LLC and CenturyLink Communications, LLC 100 CenturyLink Dr. Monroe, LA 71203
POLICY NUMBER	
CARRIER / NAIC CODE	EFFECTIVE DATE:

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,
FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

---------- GENERAL LIABILITY ----------

Automatic Additional Insured's Primary Coverage
Additional Insured as respects your interest in the operations of the Named Insured as required by contract or agreement.
Coverage provided by the above General Liability policy shall be primary and is limited to liability arising out of Named Insured's ownership and/or operations. Any insurance carried by the additional insured shall not be contributory insurance.
Waiver of Transfer of Rights of Recovery Against Others to Us (Waiver of Subrogation) – any person or organization with whom you have entered into a contract or agreement, or by statute, law or code of ordinance. Separation of Insureds Applies. Insurance covers incidents that occur within 50' of railroad property, any railroad exclusions have been deleted per endorsement CG2417.

---------- AUTOMOBILE LIABILITY ----------

Any person or organization you are required in a written contract, agreement, statute, law or code of ordinances provided the "bodily injury" or "property damage" occurs subsequent to the executive of the contract, agreement, statute, law or code of ordinances.
Lessor - Additional Insured and Loss Payee - All Lessors
Waiver of Transfer of Rights of Recovery Against Others to Us (Waiver of Subrogation) – Any person or organization with whom you have waived prior to the "accident" or the "loss" under a contract with that person or organization, or under statute, law or code of ordinances.

---------- WORKERS' COMPENSATION AND EMPLOYER'S LIABILITY AND EXCESS WORKERS' COMPENSATION AND EMPLOYER'S LIABILITY (OH & WA - SELF-INSURED - $1,000,000 RETENTION) ----------

Waiver of Our Right to Recover from others Endorsement – Where required by written agreement signed prior to loss, or required by statute, law or code of ordinances executed prior to loss.

---------- EXCESS/UMBRELLA ----------
Coverage applies per occurrence. Additional Insured as respects your interest in the operations of the Named Insured as required by contract or agreement. Waiver of Transfer of Rights of Recovery Against Others to Us (Waiver of Subrogation) - Any person or organization with whom you have entered into a contract or agreement, but only to the extent required by such contract or agreement. Separation of Insureds Applies.

---------- COMMERCIAL CRIME - FIDELITY BOND ----------
Carrier: XL Specialty Insurance Company
Policy Number: ELU18499022
Effective Dates: 09/01/2022 - 09/01/2023
Deductible: $2,500,000
Each Occurrence: $15,000,000

---------- U.S. PROPERTY ----------
Carrier: Allianz Underwriters Insurance Company
Policy Number: U5Z000023220
Effective Dates: 09/01/2022 - 09/01/2023
Limit: $25,000,000
Deductible: $25,000,000

Property Coverage: "All Risk" of Direct Physical Loss or Damage to All Real and Personal Property, including Boiler & Machinery, Earthquake, Flood and Wind - Replacement Cost Basis, and Business Interruption - Actual Loss Sustained.
Loss Payee or mortgagee as required by written contract/loan agreement to the the extent of your insurable interest. Waiver of Subrogation - Any person or organization whom you have entered into a contract or agreement, but only to the extent required by such contract or agreement. Other deductibles may apply as per policy terms and conditions.

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City of Santa Fe

Treasury Department
200 Lincoln Ave.
Santa Fe, New Mexico 87504-0909
505-955-6551

BUSINESS REGISTRATION

Business Name: CENTURYLINK COMMUNICATIONS, LLC
DBA: LUMEN TECHNOLOGIES GROUPS & ITS AFFILIATED ENTITIES

Business Location: 2701 SAWMILL RD
SANTA FE , NM 87505

CRS Number: 01-602313-00-7

Owner: CENTURYLINK COMMUNICATIONS, LLC

License Number: 32485

License Type: Business License - Renewable

Issued Date: March 07, 2022

Classification: Business Registration - Standard

Expiration Date: March 07, 2023

Fees Paid: $35.00

CENTURYLINK COMMUNICATIONS, LLC
400 TIJERAS AVE NW 530
ALBUQUERQUE, NM 87102

THIS IS NOT A CONSTRUCTION PERMIT OR SIGN PERMIT. APPROPRIATE PERMITS MUST BE OBTAINED FROM THE CITY OF SANTA FE BUILDING PERMIT DIVISION PRIOR TO COMMENCEMENT OF ANY CONSTRUCTION OR THE INSTALLATION OF ANY EXTERIOR SIGN.

THIS REGISTRATION/LICENSE IS NOT TRANSFERRABLE TO OTHER BUSINESSES OR PREMISES.

TO BE POSTED IN A CONSPICUOUS PLACE

Signature: Manuel Gonzales (Oct 19, 2022 09:14 MDT)

Email: mmgonzales@ci.santa-fe.nm.us

CENTURYLINK GEOMAX® SERVICE
Intrastate

ITEM # 19-0871

Agreement Number: _____
Billing Number: _____

This GeoMax Service ("Service") Agreement ("Agreement") is between Qwest Corporation d/b/a CenturyLink QC ("CenturyLink") and CITY OF SANTA FE ("Customer") and is effective on the date CenturyLink signs it ("Effective Date").

Tariff

Service will be governed by: (a) the Tariff applicable to Service; and (b) to the extent a comparable Tariff term or condition does not apply to Service, the terms and conditions set forth in this Agreement. "Tariff" includes as applicable: CenturyLink state tariffs, price lists, price schedules, administrative guidelines, catalogs, and rate and term schedules incorporated by this reference and posted at http://www.centurylink.com/tariffs. Service is subject to technical publication 77407 located at http://www.centurylink.com/techpub/ ("Tech Pub").

1. Scope.

1.1 CenturyLink will provide, and Customer will purchase, the Service provided under this Agreement. CenturyLink will provide Service up to the Standard Network Interface ("SNI") at Customer's premises. The SNI is that location where CenturyLink's protected network facilities end and Customer's inside wire or network begins, normally at a fiber distribution panel ("FDP").

1.2 Service is a robust, high speed, multi-protocol, fiber optic data transport service. It utilizes Dense Wave Division Multiplexing ("DWDM") technology enabling two or more optical signals having different wavelengths to be transmitted simultaneously in the same direction over one strand of fiber. Specific customer interfaces are listed in the Payment section.

1.3 To ensure diversity on "Protected Service," fiber optic paths will be separated by a minimum of 25 feet (where available) at all points to the last manhole. If one fiber optic path fails, Service will switch automatically to the other path within 50 milliseconds.

1.4 Customer understands and agrees that CenturyLink supplies Service as an intrastate, intraLATA telecommunications service, as defined by State and/or Federal Communications Commission ("F.C.C.") regulations, which are incorporated herein by this reference. It is Customer's responsibility to ensure that Customer uses Service as an intrastate, intraLATA telecommunications service consistent with such regulations. F.C.C. regulations permit interstate usage of Service if such usage does not exceed 10% of the total usage. If Customer should use this Service for any other purpose, or if interstate usage exceeds 10%, it is Customer's responsibility to immediately notify CenturyLink of such use and to place an order for appropriate service. CenturyLink will bill, and Customer will promptly pay, appropriate monthly recurring charges, for such use of and changes to Customer's telecommunications service including, but not limited to all applicable CenturyLink Rates and Services Schedule No. 1 interstate access charges or intrastate Tariff access charges.

1.5 "Construction" means when Service may not be available due to facilities limitations and it is necessary for CenturyLink to construct facilities. "Funding" means charges to Customer over the term of a Service contract covering CenturyLink's calculated costs for providing Service and it's expected rate of return when network infrastructure is not available to provide Service to Customer. CenturyLink may assess separate Construction charges if facilities are not available to meet an order for Service and CenturyLink constructs facilities under one or more of the following circumstances: (a) the amount of Customer's expected payments over the term of the Agreement does not exceed CenturyLink's calculated cost of providing the Service plus its expected rate of return; (b) Customer requests that Service be furnished using a type of facility, or via a route that CenturyLink would not normally utilize in providing the requested Service; (c) more facilities are requested than would normally be required to satisfy an order; and (d) Customer requests that Construction be expedited, resulting in added cost to CenturyLink. Service provided under this Agreement is subject to Funding approval and that approval will be evidenced in the Funding Concurrence block on this Agreement. That approval will be granted at the sole discretion of CenturyLink. In the event contract documents are signed under which Customer is ordering Service for which Funding is not approved, CenturyLink will cooperate with Customer in good faith to develop an alternative service solution if Funding cannot be achieved on the contracted solution and CenturyLink may immediately terminate this Agreement, without penalty, if Funding of the contracted and alternate Service solutions are determined to not be possible.

1.6 Filing Concurrence. CenturyLink may be required to submit an Agreement for a particular Service and any subsequent addenda for Service to certain regulatory agencies for approval because the rates in the Agreement are being offered on an individual case basis ("ICB"). Although the general terms and conditions of this Agreement are effective on the Effective Date, those service-specific rates, terms, and conditions that require filing with or approval by regulatory agencies ("ICB Terms") will not become effective for a given jurisdiction until the filing and approval requirements for that jurisdiction are fulfilled. Service will be offered in accordance with the applicable Tariff until the ICB Terms become effective. If Customer receives reduced pricing under the Agreement and a regulatory agency later invalidates the ICB Terms after they had become effective, Customer will pay to CenturyLink any difference in the amounts listed in the applicable Tariff for the Service and the amounts Customer was charged for the Service. When approved by the regulatory agencies, Customer may add additional quantities of Services pursuant to Section 9 under the same terms and conditions with no further filing required. In the event a regulatory agency does not approve the Agreement, the parties will enter into good faith negotiations to mutually resolve the failure to receive the necessary approval. The Agreement for a particular Service remains in full force and effect for Service in all other jurisdictions.

1.7 Service Level Agreement. The SLA provides Customer's sole and exclusive remedy for service interruptions or service deficiencies of any kind whatsoever for Service. "SLA" means the GeoMax service level agreement located at http://www.centurylink.com/legal/sla.html which is subject to change.

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1.8 Service/Maintenance. CenturyLink may from time to time suspend Service for routine maintenance or rearrangement of facilities or equipment. CenturyLink will give advance notification of any such suspension of Service. Such suspension of Service is not considered an out-of-service condition unless Service is not restored by the end of the period specified in the notification.

2. Term.

2.1 This Agreement is effective on the date on which it is executed by CenturyLink following Customer's execution of this Agreement ("Effective Date") and expires 48 months from the date Service requested under this Agreement is available to Customer, as evidenced by CenturyLink records ("Term"), consistent with NMSA 1978, sec. 13-1-150.

2.2 Both Parties agree to begin discussions regarding the renewal or discontinuation of this Agreement 90 days prior to its expiration. In the event negotiation cannot be met and CenturyLink continues to provide Service after the Term, Service will automatically revert to month-to-month rates. Month-to-month rates are only available upon completion of a fixed period service rate plan. Service provided on a month-to-month basis cannot be added to or changed. Month-to-month service may only be upgraded to a fixed period service rate plan of 36- or 60-months, or disconnected.

3. Charges and Billing.

3.1 Customer must pay CenturyLink all charges by the payment due date on the invoice. Any amount not paid when due is subject to late interest specified by the Tariff, or if there is no such late interest specified in the Tariff, the amount due will be subject to late interest at the lesser of 1.5% per month or the maximum rate allowed by law. In addition to payment of charges for Service, Customer must also pay CenturyLink any applicable Taxes assessed in connection with Service. "Taxes" means federal, state, and local excise, gross receipts, sales, use, privilege, or other tax (other than net income) now or in the future imposed by any governmental entity (whether such Taxes are assessed by a governmental authority directly upon CenturyLink or Customer) attributable or measured by the sale price or transaction amount, or surcharges, fees, and other similar charges that are required or permitted to be assessed on Customer. These charges may include state and federal Carrier Universal Service Charges, as well as charges related to E911, and Telephone Relay Service. Taxes may vary and are subject to change. Customer may access its invoices and choose paperless invoices online through CenturyLink Control Center located at controlcenter.centurylink.com. If Customer does not choose paperless invoices through Control Center, CenturyLink may in its discretion assess a $15 MRC for each full paper invoice provided to Customer or a $2 MRC for each summary/remit only (where available) paper invoice provided to Customer. Those charges will not apply to an invoice that is not available through Control Center. Customer's payments to CenturyLink must be in the form of electronic funds transfer (via wire transfer or ACH), cash payments (via previously-approved CenturyLink processes only), or paper check. CenturyLink reserves the right to charge administrative fees when Customer's payment preferences deviate from CenturyLink's standard practices.

3.2 Service's Monthly Recurring Charge ("MRC") and Nonrecurring Charges ("NRC") will be those stated in the Tariff on: (a) the date of installation for new Service; or (b) the Effective Date for existing Service. CenturyLink will protect the MRC from any CenturyLink-initiated price increases during the Term. Any rate increases directed or mandated by a regulatory body with proper authority will increase the MRCs and/or NRCs pursuant to the applicable order. Customer agrees to pay the charges for Service as specified in this Agreement. Customer's payment obligations are not contingent upon Customer's ability to collect payments or charges from any third party.

3.3 Order Acceptance and Cancellation. CenturyLink and Customer will determine a mutually agreeable date for Service to be available for use. Customer's acceptance of Service will be subject to the terms in the applicable Tariff. If the order for Service is canceled (a) at Customer's request; or (b) by CenturyLink due to Customer's failure to accept Service, Customer will be subject to cancellation charges in the applicable Tariff.

3.4 Customer hereby orders and agrees to pay the following charges for Service as shown below:

Customer Interface:

Port Type/Name	Port Speed	No. of Ports	Unprotected/Protected	MRC/each	NRC/each
Gigabit Ethernet	1.25 Gbps	68	Unprotected	$330.00	$0.00
			Monthly Total	**$22,440.00**	
			12 Month Total	**$269,280.00**	
			48 Month Total	**$1,077,120.00**	

Network Access Channel (NAC):

Quantity (34)	CO Node Location	MRC/each	NRC/each
1	2515 Camino Entrada Santa Fe, NM 87507	$102.00	$0.00
1	6599 Jaguar Dr Santa Fe, NM 87507	$102.00	$0.00
1	6796 Jaguar Dr Santa Fe, NM 87507	$102.00	$0.00
1	801 W San Mateo Rd Santa Fe, NM 87505	$102.00	$0.00

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1	490 Bishops Lodge Rd Santa Fe, NM 87501	$102.00	$0.00
1	1730 Llano St Santa Fe, NM 87505	$102.00	$0.00
1	35 Camino Justicia Santa Fe, NM 87508	$102.00	$0.00
1	301 Montezuma Ave Santa Fe, NM 87501	$102.00	$0.00
1	1751 Cerrillos Rd Santa Fe, NM 87505	$102.00	$0.00
1	737 Agua Fria St Santa Fe, NM 87501	$102.00	$0.00
1	2651 Siringo Rd Santa Fe, NM 87505	$102.00	$0.00
1	1030 W Alameda St Santa Fe, NM 87501	$102.00	$0.00
1	1121 Alto St Santa Fe, NM 87501	$102.00	$0.00
1	1142 Siler Rd Santa Fe, NM 87507	$102.00	$0.00
1	2391 Richards Ave Santa Fe, NM 87507	$102.00	$0.00
1	2931 Rufina St Santa Fe, NM 87507	$102.00	$0.00
1	500 Market St Santa Fe, NM 87501	$102.00	$0.00
1	1130 Arroyo Chamiso Rd Santa Fe, NM 87505	$102.00	$0.00
1	2511 Camino Entrada Santa Fe, NM 87507	$102.00	$0.00
1	601 Alta Vista St Santa Fe, NM 87505	$102.00	$0.00
1	216 W San Francisco St Santa Fe, NM 87501	$102.00	$0.00
1	3221 Rodeo Rd Santa Fe, NM 87507	$102.00	$0.00
1	205 Caja Del Rio Rd, Santa Fe, NM 87507	$102.00	$0.00
1	73 Paseo Real Santa Fe, NM 87507	$102.00	$0.00
1	6601 Valentine Way Santa Fe, NM 87507	$102.00	$0.00
1	100 Caja Del Rio Rd Santa Fe, NM 87507	$102.00	$0.00
1	121 Aviation Dr Santa Fe, NM 87507	$102.00	$0.00
1	145 Washington Ave Santa Fe, NM 87501	$102.00	$0.00
1	715 Alta Vista St Santa Fe, NM 87505	$102.00	$0.00
1	1600 St Michaels Dr Santa Fe, NM 87505	$102.00	$0.00
1	200 Lincoln Ave Santa Fe, NM 87501	$102.00	$0.00
1	341 CAJA DEL RIO RD, SANTA FE, NM 87506	$102.00	$0.00
1	66 E SAN FRANCISCO ST, SANTA FE, NM, 87501	$102.00	$0.00
1	200 MURALES RD, SANTA FE, NM, 87501-1173	$102.00	$0.00
	1 Month Total	**$3,468.00**	
	12 Month Total	**$41,616.00**	
	48 Month Total	**$166,464.00**	

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Nodes (includes first shelf in each node):

Node Type (Premise of CO)	Quantity	Location	MRC/each
Premise	1	715 ALTA VISTA ST, SANTA FE, NM, 87505	$2,188.80
CO	1	121 E ALAMEDA ST, SANTA FE, NM, 87501	$1,732.80
CO	1	1117 CALLE LA RESOLANA, SANTA FE, NM, 87507	$1,732.80
		1 Month Total	**$5,654.40**
		12 Month Total	**$67,852,80**
		48 Month Total	**$271,411.20**

4. Customer Responsibilities. Customer is responsible for the following:

4.1 Environmental Requirements. Customer will ensure that the environment at Customer's premises in which CenturyLink equipment will reside meets all applicable local, state, and/or national safety codes. Customer is required to provide adequate building space, lighting, and atmospheric control (humidity, temperature, and ventilation) for the proper installation, operation, and maintenance of CenturyLink equipment and facilities on the Customer premises. Customer will provide written notice to CenturyLink of any health or safety hazards known by Customer to exist arising from or related to Customer's operations to which CenturyLink employees may be exposed while working at Customer premises and any required control measures necessary to prevent hazardous exposures to CenturyLink employees.

4.2 Power Requirements. Customer will provide the appropriate alternating current ("AC") power supply as specified by CenturyLink based on the customer specific network design for normal operations of CenturyLink electronic equipment. All power supply sources will comply with national standards and safety codes. Customer should also extend a suitable ground source to the telecommunications equipment area. In the event a Service outage(s) occurs due to AC power failure, and backup power is provided by Customer (not CenturyLink), and such backup power also fails, CenturyLink will be exempt from meeting the specified SLAs for such Service outage(s).

4.3 Access. Customer will provide prompt access to its premises to CenturyLink authorized personnel or other authorized parties, responding to Service restoration, equipment failure, maintenance, or other relevant situations, and such access to CenturyLink equipment will be available 24 hours a day, 365 days a year.

4.4 On-Site Operations. All Customer operations concerning Service at Customer's premises will be performed at the expense of Customer, and Customer will be required to conform to all applicable specifications that CenturyLink may adopt as necessary to maintain Service. Any special structural work required for supporting telecommunications facilities needed in order to provide Service on Customer's premises will be provided at the expense of Customer.

5. Optional Performance Monitoring.

5.1 CenturyLink will monitor and manage the Service 24 hours a day, 365 days a year.

5.2 Customer will provide, at Customer's own expense, a terminal compatible with the CenturyLink equipment used to provision Service to allow read-only monitoring of the Service.

6. Equipment and Installation.

6.1 CenturyLink will provide, install, maintain, repair, operate, and have sole access to the equipment necessary for Service. CenturyLink will pay the cost of purchasing and installing all fiber and equipment necessary for Service; however, any special construction for additional fiber that is nonreusable or nonrecoverable (as determined by CenturyLink) will be at an additional charge to Customer. Customer will be notified in writing of any such charges prior to execution of this Agreement.

6.2 CenturyLink will procure and maintain at CenturyLink's expense, all rights-of-way and private or public easements or licenses required for the installation of CenturyLink's equipment and fiber.

6.3 The fiber and equipment will remain the sole and exclusive property of CenturyLink or its assignee, and nothing contained herein will give or convey to Customer any right, title, or interest whatsoever in such fiber and equipment, except as otherwise provided herein. Such fiber and equipment is and will remain personal property, notwithstanding that it may be, or become, attached to or embedded in realty.

7. Service Changes.

7.1 Additions and/or changes to Service elements at the specified locations may be added at existing agreement rates through and including the 24th month of this Agreement, and such additions and/or changes will be subject to all terms of this Agreement, including the Term. Additions and/or changes to Service will be handled by written amendment mutually agreed upon by the Parties, some elements of

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Service may not be changeable, CenturyLink has the right to not change certain elements of Service. New rate elements cannot be added during the last 12 months of this Agreement. Customer agrees to pay all MRCs and NRCs related to the changes.

7.2 In the event Customer requests additional Service with fewer than 12 months remaining in the Term, Customer will be required to enter into a separate agreement.

7.3 Customer may move or add to the Service ("Change") if CenturyLink commercially offers the Change to the Service, and Customer agrees to pay all applicable charges related to the Change, including all then-current MRCs and NRCs and any excess construction charges.

8. Termination.

8.1 Either party may terminate Service and/or this Agreement in accordance with the applicable Tariff or for Cause. "Cause" means the failure of a party to perform a material obligation under this Agreement, which failure is not remedied: (a) for payment defaults by Customer, within five days of separate written notice from CenturyLink of such default (unless a different notice period is specified in the Tariff); or (b) for any other material breach, within 30 days of written notice (unless a different notice period is specified in the Tariff or this Agreement). Customer will remain liable for charges accrued but unpaid as of the termination date. Prior to the conclusion of the Term, if Service and/or this Agreement is terminated either by CenturyLink for Cause or by Customer for any reason other than Cause, then Customer will also be liable for a termination charge "Termination Charge" of:

(a) If during the first 12 months of Service ("Minimum Service Period"), Customer will pay all accrued and unpaid charges for Service provided through the effective date of such termination plus a Termination Charge of 100% of the MRCs for the terminated Service (or any fraction thereof), multiplied by the number of months, or portion thereof, remaining in the Minimum Service Period, plus 70% of the MRCs for the terminated Service (or any fraction thereof), multiplied by the number of months after the Minimum Service Period remaining in the Initial Term.

(b) If after the Minimum Service Period, Customer will pay for all accrued and unpaid charges for Services provided through the effective date of such termination plus a Termination Charge of 70% of the MRCs for the terminated Service (or any fraction thereof), multiplied by the number of months, or portion thereof, remaining in the Initial Term.

8.3 CenturyLink may: (a) immediately suspend all or any part of the Service; and/or (b) terminate this Agreement (effective after the applicable notice period): (i) for Cause (as defined herein); or (ii) upon written notice if Customer becomes or is declared insolvent or bankrupt or is the subject of any proceedings related to its liquidation, insolvency or for the appointment of a receiver or similar officer for it.

9. Confidentiality. Neither party will, without the prior written consent of the other party: (a) disclose any of the terms of this Agreement; or (b) disclose or use (except as expressly permitted by, or required to achieve the purposes of, this Agreement) the Confidential Information of the other party. "Confidential Information" means any information that is not generally available to the public, whether of a technical, business, or other nature, and that: (a) the receiving party knows or has reason to know is confidential, proprietary, or trade secret information of the disclosing party; or (b) is of such a nature that the receiving party should reasonably understand that the disclosing party desires to protect the information from disclosure. Confidential Information will not include information that is in the public domain through no breach of this Agreement by the receiving party or is already known or is independently developed by the receiving party. Each party will use reasonable efforts to protect the other's Confidential Information, and will use at least the same efforts to protect such Confidential Information as the party would use to protect its own. CenturyLink's consent may only be given by its Legal Department. A party may disclose Confidential Information if required to do so by a governmental agency, by operation of law, or if necessary in any proceeding to establish rights or obligations under this Agreement.

10. Use of Name and Marks. Neither party will use the name or marks of the other party or any of its Affiliates for any purpose without the other party's prior written consent. CenturyLink's consent may only be given by its Legal Department. "Affiliate" means any entity controlled by, controlling, or under common control with a party.

11. Disclaimer of Warranties. EXCEPT AS EXPRESSLY PROVIDED IN THIS AGREEMENT, SERVICE IS PROVIDED "AS IS." CENTURYLINK DISCLAIMS ALL EXPRESS OR IMPLIED WARRANTIES, INCLUDING BUT NOT LIMITED TO ALL WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, AND NON-INFRINGEMENT.

12. Limitations of Liability. The remedies and limitations of liability for any claims arising between the parties are set forth below.

12.1 Consequential Damages. NEITHER PARTY OR ITS AFFILIATES, AGENTS, OR CONTRACTORS IS LIABLE FOR ANY CONSEQUENTIAL, INCIDENTAL, INDIRECT, SPECIAL, OR PUNITIVE DAMAGES OR FOR ANY LOST PROFITS, LOST REVENUES, LOST DATA, LOST BUSINESS OPPORTUNITY, OR COSTS OF COVER. THESE LIMITATIONS APPLY REGARDLESS OF THE LEGAL THEORY UNDER WHICH SUCH LIABILITY IS ASSERTED AND REGARDLESS OF FORESEEABILITY.

12.2 Claims Related to Service. For Service related claims by Customer, Customer's exclusive remedies are limited to the applicable out-of-service credits, if any.

12.3 Personal Injury; Death; Property Damages. For claims arising out of personal injury or death to a party's employee, or damage to a party's real or personal property, that are caused by the other party's negligence or willful misconduct in the performance of this Agreement, each party's liability is limited to proven direct damages.

13. Miscellaneous.

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13.1 General. This Agreement's benefits do not extend to any third party (e.g., an End User). "End User" means Customer's members, end users, customers, or any other third parties who use or access Service or the CenturyLink network via Service. If any term of this Agreement is held unenforceable, the remaining terms will remain in effect. Neither party's failure to exercise any right or to insist upon strict performance of any provision of this Agreement is a waiver of any right under this Agreement. The terms and conditions of this Agreement regarding confidentiality, limitation of liability, warranties, payment, dispute resolution, and all other terms of this Agreement that should by their nature survive the termination of this Agreement will survive. Each party is not responsible for any delay or other failure to perform due to a Force Majeure Event. "Force Majeure Event" means an unforeseeable event beyond the reasonable control of that party, including without limitation: act of God, fire, explosion, lightning, hurricane, labor dispute, cable cuts by third parties, acts of terror, material shortages or unavailability, government laws or regulations, war or civil disorder, or failures of suppliers of goods and services. Customer may not assign this Agreement or any of its rights or obligations under this Agreement without the prior written consent of CenturyLink, which consent will not be unreasonably withheld. Customer may not assign to a reseller or a telecommunications carrier under any circumstances and Customer represents that it will not resell Service.

13.2 Conflicts Provision. If a conflict exists among provisions within this Agreement, the following order of precedence will apply in descending order of control: Tariff, this Agreement, the Tech Pub and CenturyLink records.

13.3 Independent Contractor. CenturyLink provides Service as an independent contractor. This Agreement will not create an employer-employee relationship, association, joint venture, partnership, or other form of legal entity or business enterprise between the parties, their agents, employees or affiliates.

13.4 ARRA. Customer will not pay for Service with funds obtained through the American Recovery and Reinvestment Act or other similar stimulus grants or loans that would obligate CenturyLink to provide certain information or perform certain functions unless each of those obligations are explicitly identified and agreed to by the parties in this Agreement or in an amendment to this Agreement.

13.5 HIPAA. CenturyLink Communications, LLC does not require or intend to access Customer data in its performance hereunder, including but not limited to any confidential health related information of Customer's clients, which may include group health plans, that constitutes Protected Health Information ("PHI"), as defined in 45 C.F.R. §160.103 under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Rules"). To the extent that any exposure to PHI is incidental to CenturyLink's provision of Service and not meant for the purpose of accessing, managing the PHI or creating or manipulating the PHI, such exposure is allowable under 45 CFR 164.502(a)(1)(iii).

13.6 Credit Approval. Provision of Service is subject to CenturyLink's credit approval of Customer. As part of the credit approval process, CenturyLink may require Customer to provide a deposit or other security. Additionally during the Term, if Customer's financial circumstance or payment history becomes reasonably unacceptable to CenturyLink, CenturyLink may require adequate assurance of future payment as a condition of continuing CenturyLink's provision of Service. Customer's failure to provide adequate assurances required by CenturyLink is a material breach of this Agreement. CenturyLink may provide Customer's payment history or other billing/charge information to credit reporting agencies or industry clearinghouses.

13.7 Governing Law; Dispute Resolution.

(a) Governing Law; Forum. New Mexico state law, without regard to choice-of-law principles, governs all matters relating to this Agreement, except with regard to matters which are within the exclusive jurisdiction of the state or federal regulatory agency. Any legal proceeding relating to this Agreement will be brought in a U.S. District Court, or absent federal jurisdiction, in a state court of competent jurisdiction, in Santa Fe, New Mexico. This provision is not intended to deprive a small claims court or state agency of lawful jurisdiction that would otherwise exist over a claim or controversy between the parties. Each party will comply with all applicable laws, rules and regulations associated respectively with CenturyLink's delivery or Customer's use of the Service under the Agreement.

(b) Limitations Period. Any claim relating to this Agreement must be brought within two years after the claim arises.

13.8 No Resale; Compliance. Customer represents that it is not a reseller of any telecommunication services provided under this Agreement as described in the Telecommunications Act of 1996, as amended, or applicable state law and acknowledges it is not entitled to any reseller discounts under any laws. Customer's use of Service must comply with all applicable laws.

13.9 Amendments; Changes. This Agreement may be amended only in a writing signed by both parties' authorized representatives. Each party may, at any time, reject any handwritten change or other alteration to this Agreement. CenturyLink may amend, change, or withdraw the Tariffs, with such updated Tariffs effective upon posting or upon fulfillment of any necessary regulatory requirements.

13.10 Notices. All notices must be in writing. Notices are deemed given if sent to the addressee specified for a party either: (a) by registered or certified U.S. mail, return receipt requested, postage prepaid, three days after such mailing; or (b) by national overnight courier service, next business day; or (c) by facsimile when delivered if duplicate notice is also sent by regular U.S. Mail.

(a) Service Notices. All Customer notices for Service disconnect and termination must be sent via e mail to: CenturyLink, Attn.: BusinessDisconnects@centurylink.com and must contain the account name, account number, identification of the Service(s), and Service address(es). Such disconnect and termination is effective 30 days after CenturyLink's receipt of the notice. All Customer notices for Service non-renewal and other routine operational notices will be provided to its CenturyLink sales representative. Failure to provide disconnect, termination and non-renewal notices in accordance with the terms of this Agreement may result in continued charges, and CenturyLink will not credit charges for such noncompliance.

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(b) Legal Notice. All legal notices required to be given under the Agreement will be in writing and provided to CenturyLink at: 931 14th St., #900, Denver, CO 80202; Fax: 888-778-0054; Attn.: Legal Dept., and to Customer as provided in the Agreement or in its absence, to Customer's address reflected in CenturyLink's records Attn. General Counsel.

13.11 Termination

This Agreement may be terminated by the Customer upon 60 days written notice to CenturyLink.

13.12 Indemnification

CenturyLink shall indemnify, hold harmless and defend the Customer from all losses, damages, claims or judgments, including payments of all attorneys' fees and costs on account of any suit, judgment, execution, claim, action or demand whatsoever arising from CenturyLink's performance under this Agreement as well as the performance of CenturyLink's employees, agents, representatives and subcontractors.

13.13 New Mexico Tort Claims Act

Any liability incurred by the Customer in connection with this Agreement is subject to the immunities and limitations of the New Mexico Tort Claims Act, Section 41-4-1, et. seq. NMSA 1978, as amended. The Customer and its "public employees" as defined in the New Mexico Tort Claims Act, do not waive sovereign immunity, do not waive any defense and do not waive any limitation of liability they may have pursuant to applicable law.

13.14 Non-Appropriations. Customer intends to continue this Agreement for its entire Term and to satisfy its obligations hereunder. For each fiscal period for Customer: (a) Customer agrees to include in its budget request appropriations sufficient to cover Customer's obligations under this Agreement; (b) Customer agrees to use all reasonable and lawful means to secure these appropriations; (c) Customer agrees it will not use non-appropriations as a means of terminating this Agreement in order to acquire functionally equivalent products or services from a third party. Customer reasonably believes that sufficient funds to discharge its obligations can and will lawfully be appropriated and made available for this purpose. In the event that Customer is appropriated insufficient funds, by appropriation, appropriation limitation or grant, to continue payments under this Agreement and has no other funding source lawfully available to it for such purpose (as evidenced by notarized documents provided by Customer and agreed to by CenturyLink), Customer may terminate this Agreement without incurring any termination charges by giving CenturyLink not less than 30 days' prior written notice. Upon termination and to the extent of lawfully available funds, Customer will remit all amounts due and all costs reasonably incurred by CenturyLink through the date of termination.

13.15 Third Party Beneficiaries

By entering into this Agreement, the parties do not intend to create any right, title or interest in or for the benefit of any person other than the Customer and CenturyLink. No person shall claim any right, title or interest under this Agreement or seek to enforce this Agreement as a third party beneficiary of this Agreement.

13.19 Insurance

A. CenturyLink, at its own cost and expense, shall carry and maintain in full force and effect during the term of this Agreement, comprehensive general liability insurance covering bodily injury and property damage liability, in a commercially available form and with an insurance company with minimum AM Best's rating of A-VII, with limits of coverage in the maximum amount which the Customer could be held liable under the New Mexico Tort Claims Act for each person injured and for each accident resulting in damage to property. Such insurance shall provide that the Customer is included as an additional insured. The Customer will be notified by CenturyLink no less than 30 days in advance of cancellation for any reason. CenturyLink shall furnish the Customer with a copy of a Certificate of Insurance as a condition prior to performing services under this Agreement.

B. CenturyLink shall also obtain and maintain Workers' Compensation insurance, required by law, to provide coverage for CenturyLink's employees throughout the term of this Agreement. CenturyLink shall provide the Customer with evidence of its compliance with such requirement.

C. CenturyLink shall maintain professional liability insurance throughout the term of this Agreement providing a minimum coverage in the amount required under the New Mexico Tort Claims Act. CenturyLink shall furnish the Customer with proof of insurance of CenturyLink's compliance with the provisions of this section as a condition prior to performing services under this Agreement.

13.20 Records and Audit

CenturyLink shall maintain reasonably comprehensive books and records of the Services performed to the extent necessary to substantiate the fees charged to Customer under the Agreement. Such books and records will be retained by CenturyLink for a period of at least two (2) years, or longer if required by applicable law, from and after the completion of such Services. Once each calendar year, upon at least thirty (30) days written notice from Customer, CenturyLink shall provide Customer and Customer's agents (including any third party auditor(s) designated by Customer) which have entered into a mutually agreeable non-disclosure agreement and agree to comply with rules for the facility, which will be provided to Customer or its auditor(s) as applicable in advance, at Customer's expense, with access during normal business days and hours to such books and records and documentation which support charges billed to Customer as may be reasonably requested by Customer that cover any period not to exceed 2 years from the date of the audit to determine that fees charged are accurate and in accordance with the Agreement.

13.24 Severability

In case any one or more of the provisions contained in this Agreement or any application thereof shall be invalid, illegal or unenforceable in any respect, the validity, legality, and enforceability of the remaining provisions contained herein and any other application thereof shall not in any way be affected or impaired thereby.

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13.25 Entire Agreement. This Agreement (including all referenced documents) constitutes the entire agreement between the parties and supersedes all prior oral or written agreements or understandings relating to the same service or circuits at the same locations as covered under this Agreement. Using CenturyLink's electronic signature process for this Agreement is acceptable.

QWEST CORPORATION D/B/A CENTURYLINK QC

Dan Sullivan
Authorized Signature

Dan Sullivan on behalf of Susan Baker
Name Typed or Printed

Lead SLED Relationship Manager
Title

8-14-2019
Date

CITY OF SANTA FE

Authorized Signature

Alan Webber
Name Typed or Printed

Mayor
Title

11/20/19
Date

Customer's Address for Notice:
Customer's facsimile number (if applicable):
Person designated for notices:

FOR CENTURYLINK INTERNAL USE ONLY
FUNDING CONCURRENCE REQUIRED PRIOR TO EXECUTION FOR NEW SERVICE (NOT REQUIRED FOR RENEWALS)
AQCB Quote No.
Date Concurred:

IN WITNESS WHEREOF, the parties have executed this Agreement on the date set forth below.

ATTEST:

YOLANDA Y. VIGIL CCMTG 11/13/19
CITY CLERK

APPROVED AS TO FORM:

8/15/19
ERIN MCSHERRY, CITY ATTORNEY
APPROVED:

MARY MCCOY, FINANCE DIRECTOR

~~Business Unit Line Item~~
620 3650.514100

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v1.022119

City of Santa Fe, New Mexico
Memorandum

DATE: October 24, 2022

TO: Governing Body
Quality of Life Committee
Finance Committee

VIA: Kyra Ochoa, Community Health and Safety Director
Gino Rinaldi, Senior Services Division Director

FROM: Anya Alarid, Volunteer Program Manager

ITEM AND ISSUE:
Request for the Approval of Fiscal Year 2023 Grant Contract in the Total Amount of $ 89,058 for the Foster Grandparent and Retired Senior Companion Volunteer Programs; Corporation for National and Community Service; Anya Alarid, Volunteer Program Manager aalarid@santafenm.gov 505-955-4744

BACKGROUND AND SUMMARY:

The Senior Services Department is requesting the approval of the Federal Grant Agreement with the Corporation for National and Community Service for the Senior Volunteer Programs. The Grant Award is for the Foster Grandparent and Retired Senior Companion Volunteer Programs. The attached Notice of Grant Award reflects the Fiscal Year 2023 awarded appropriations for the Volunteer Programs. The allocations are as follows; Foster Grandparent Program $32,687, Retired Senior Volunteer Program $56,371.

Our Foster Grandparent Program provides opportunities for our senior volunteers to assist children (with special or exceptional needs) in classrooms or Head Starts. The RSVP Program recruits and provides meaningful volunteer opportunities for senior volunteers to help others by sharing their experience, knowledge, and efforts. RSVP volunteers work in food distribution sites, soup kitchens, nursing homes, hospitals, libraries, senior centers, shelters, etc.

CONTRACT NUMBER:
The FY23 Munis contract number is 3203724
Grant# F2304: PL# COM2324101-FGP-32687.00
Grant# F2301/PL#: SSD2324104-SVP-56371.00

FUNDING SOURCE:

The funding source is:
Fund Name/Number: Senior Citizens Grant/Fund 241
Munis Org Name/Number: Senior Volunteer Programs/2410116

ACTION REQUESTED:
Department Name respectfully requests your review and approval.

City of Santa Fe

Real Estate Summary of Contracts, Agreements, Amendments & Leases

Section to be completed by department

1. Munis Contract # **3203724**

Contractor: **Corporation for National and Community Service**

Description: **Administer the Senior Volunteer Programs- Foster Grandparent Program and the Retired Senior Volunteer Program**

Contract ☐ Agreement ☉ Lease / Rent ☐ Amendment ☐

Term Start Date: **07/01/2022** Term End Date: **06/30/23**

☐ Approved by Council Date: _____

Contract / Lease:

Amendment # _____ to the Original Contract / Lease # _____

Increase/(Decrease) Amount $ _____

Extend Termination Date to: _____

☐ Approved by Council Date: _____

Amendment is for:

2. **HISTORY** of Contract, Amendments & Lease / Rent - **Please Elaborate** (option: attach spreadsheet if multiple amendments)

3. **Procurement History:** _____

_____ Nov 14, 2022

Purchasing Officer Review: Date:

Comment & Exceptions: N/A

4. **Funding Source:** **US Department Health and Human Services** **Org / Object:** **REV-2410116/490510**

Andy Hopkins Nov 14, 2022

Andy Hopkins (Nov 14, 2022 09:59 MST)

Budget Officer Approval: Date:

Comment & Exceptions: **Expense-2410116/Org-Various**

Staff Contact who completed this form: **Anya Alarid** Phone # **505-955-4744**

Email: **aalarid@santafenm.gov**

To be recorded by City Clerk:

Clerk # _____

Date of Execution: _____

CITY OF SANTA FE PROCUREMENT CHECKLIST

Contractor Name: Corporation for National and Community Service

Procurement Title: FY 23 Senior Volunteer Program NOGA

Procurement Method: State Price Agreement ☐ Cooperative ☐ Sole Source ☐ Other ☑

Exempt ☐ Request For Proposal (RFP) ☐ Invitation To Bid (ITB) ☐ Contract under 60K ☐ Contract over 60K ☑

Department Requesting Senior Services Staff Name Anya Alarid

Procurement Requirements:

A procurement file shall be maintained for all contracts, regardless of the method of procurement. The procurement file shall contain the basis on which the award is made, all submitted bids, all evaluation materials, score sheets, quotations and all other documentation related to or prepared in conjunction with evaluation, negotiation, and the award process. The procurement shall contain a written determination from the Requesting Department, signed by the purchasing officer, setting forth the reasoning for the contract award decision before submitting to the Committees.

REQUIRED DOCUMENTS FOR APPROVAL BY PURCHASING*

YES	N/A	
☑	☐	Approved Procurement Checklist (by Purchasing)
☑	☐	Memo addressed to City Manager (under 60K) Committees/City Council (over 60K)
☐	☑	State Price Agreement
☐	☑	RFP
☐	☑	Evaluation Committee Report
☐	☑	ITB
☐	☑	Bib Tab
☐	☑	Quotes (3 valid current quotes)
☐	☑	Cooperative Agreement
☐	☑	Sole Source Request and Determination Form
☐	☑	Contractors Exempt Letter
☐	☑	Purchasing Officers approval for exempt procurement
☑	☐	BAR
☐	☑	FIR
☑	☐	Executed Contract, Agreement or Amendment
☐	☑	Current Business Registration and CRS numbers on contract or agreement
☑	☐	Summary of Contracts and Agreements form
☐	☑	Certificate of Insurance
☐	☑	All documentation presented to Committees
☐	☐	Other:

Anya Alarid	Program Manager	10/24/2022
Department Rep Printed Name (attesting that all information included)	Title	Date
	Contracts Supervisor	Nov 14, 2022
Purchasing Officer (attesting that all information is reviewed)	Title	Date

Include all other substantive documents and records of communication that pertain to the procurement and contract.

Notice of Grant Award

Corporation for National and Community Service
250 E Street SW, Suite 300
Washington, DC 20525-0001
(202) 606-5000

Retired and Senior Volunteer Program

Grantee

City of Santa Fe
200 Lincoln Ave Santa Fe NM 87504-1904

EIN: 856000168
UEI: QLN2YKMMJ8X6
DUNS: 069420818

Award Information

Agreement No.:	**20SRWNM003**	Performance Period:	**04/01/2020 - 06/30/2023**
Amendment No.:	**3**	Budget Period:	**07/01/2022 - 06/30/2023**
CFDA No.:	**94.002**	Grant Year:	**3**

Purpose

The purpose of this award is to assist the grantee in carrying out a national service program as authorized by the Domestic and Volunteer Service Act of 1973, as amended (42 U.S.C. Chapter 22).

Funding Information

Year 3	Previously Awarded This Year	This Award/ Amendment	Total Current Year
Total Obligated by CNCS	$0	$49,438	$49,438
Grantee's Unobligated Balance (Carryover)	$0	$6,933	$6,933
Total Available	$0	$56,371	$56,371

Cumulative Funding for Project Period

Total Awarded in Previous Amendments	$97,500
Total CNCS Funds Awarded to Date	**$146,938**

Funding Source and Amount

2022--OPE1-P74-OPO-26000-4101	$49,438.00

Award Description

This award funds the approved 2022–23 RSVP program. Your 2022–23 statutory match is 30% and your budgetary match is 71.3%.

This award also includes $6,371 in prior year unexpended funds.

Terms of Acceptance: By accepting funds under this grant, recipient agrees to comply with General Terms and Conditions found at [TBD] and the Program Terms and Conditions found at [TBD]. Recipient also agrees to comply with assurances and certifications made in the grant application, and applicable federal statutes, regulations and guidelines. Recipient agrees to administer the grant in accordance with the approved grant application, budgets, supporting documents, and all other representations made in support of the approved grant application.

Corporation for National and Community Service:

Notice of Grant Award

250 E Street SW, Suite 300
Washington, DC 20525-0001
(202) 606-5000

Retired and Senior Volunteer Program

Grantee

City of Santa Fe
200 Lincoln Ave Santa Fe NM 87504-1904

EIN: 856000168
UEI: QLN2YKMMJ8X6
DUNS: 069420818

Award Information

Agreement No.:	20SRWNM003	Performance Period:	04/01/2020 - 06/30/2023
Amendment No.:	3	Budget Period:	07/01/2022 - 06/30/2023
CFDA No.:		Grant Year:	3

Stacy L Bishop 05/23/2022

Signature Award Date

City of Santa Fe
Legal Applicant

Stacy Bishop
Senior Grants Officer

Anya Alarid
Project Director

Daisy Gallardo, 202-815-4248
Grants Officer

Eugene Rinaldi
Certifying Official/Executive Officer

Daisy Gallardo, 202-815-4248
Program Officer

July 12, 2022 11:54 AM

Santa Fe City RSVP

City of Santa Fe

Application ID: 22SR244796

Budget Dates: 04/01/2020 - 06/30/2023

		Total Amt	CNCS Share	Grantee Share	Excess Amount
Section I. Volunteer Support Expenses					
A. Project Personnel Expenses		87,006	23,289	63,717	0
B. Personnel Fringe Benefits		2,994	515	2,479	0
FICA		6,656	486	6,170	0
Health Insurance		25,159	5,072	20,087	0
Retirement		18,086	570	17,516	0
Life Insurance		0	0	0	0
	Total	$52,895	$6,643	$46,252	$0
C. Project Staff Travel					
Local Travel		594	594	0	0
Long Distance Travel		3,000	3,000	0	0
	Total	$3,594	$3,594	$0	$0
D. Equipment					
E. Supplies		1,786	1,110	676	0
F. Contractual and Consultant Services		4,733	4,435	298	0
I. Other Volunteer Support Costs		1,000	0	1,000	0
Criminal Background Check		247	107	140	0
	Total	$1,247	$107	$1,140	$0
J. Indirect Costs					
Section I. Subtotal		**$151,261**	**$39,178**	**$112,083**	**$0**
Section II. Volunteer Expenses					
A. Other Volunteer Costs		1,000	535	465	0
Meals		0	0	0	0
Uniforms		0	0	0	0
Insurance		4,221	2,167	2,054	0
Recognition		20,000	6,874	13,126	0
Volunteer Travel		19,959	7,617	12,342	0
	Total	$45,180	$17,193	$27,987	$0
Section II. Subtotal		**$45,180**	**$17,193**	**$27,987**	**$0**
Budget Totals		**$196,441**	**$56,371**	**$140,070**	**$0**
Funding Percentages			**28.7%**	**71.3%**	
Required Match			**30%**		
# of years Receiving CNCS Funds			**20**		

Notice of Grant Award

Corporation for National and Community Service
250 E Street SW, Suite 300
Washington, DC 20525-0001
(202) 606-5000

Foster Grandparent Program

Grantee

City of Santa Fe
200 Lincoln Ave Santa Fe NM 87504-1904

EIN: 856000168
UEI: QLN2YKMMJ8X6
DUNS: 069420818

Award Information

Agreement No.:	20SFWNM006	Performance Period:	07/01/2020 - 06/30/2023
Amendment No.:	4	Budget Period:	07/01/2022 - 06/30/2023
CFDA No.:	94.011	Grant Year:	3

Purpose

The purpose of this award is to assist the grantee in carrying out a national service program as authorized by the Domestic and Volunteer Service Act of 1973, as amended (42 U.S.C. Chapter 22).

Funding Information

Year 3	Previously Awarded This Year	This Award/ Amendment	Total Current Year
Total Obligated by CNCS	$0	$32,687	$32,687
Grantee's Unobligated Balance (Carryover)	$0	$0	$0
Total Available	$0	$32,687	$32,687

Cumulative Funding for Project Period

Total Awarded in Previous Amendments	$63,804
Total CNCS Funds Awarded to Date	$96,491

Funding Source and Amount

2022--OPE1-P71-OPO-26000-4101	$32,687.00

Award Description

This award funds the approved 2022–23 FGP program. Your 2022–23 statutory match is 10% and your budgetary match is 86.9 %.

This award begins the third year of your proposed project period of performance. This award action adds permanent funding to increase the stipend amount from $3.00 to $3.15 per hour and also includes a permanent administrative increase of $785.00.These funding augmentations changes the Total Federal funding amount to $32,687.

Terms of Acceptance: By accepting funds under this grant, recipient agrees to comply with General Terms and Conditions found at: https://americorps.gov/sites/default/files/document/FY2022-General-Terms-Conditions-508-20211119.pdf and the Program Terms and Conditions found at: https://americorps.gov/sites/default/files/document/20220228_2022FGP-SCPProgramSpecific508TC.pdf. Recipient also agrees to comply with assurances and certifications made in the grant application, and applicable federal statutes, regulations and guidelines. Recipient agrees to administer the grant in accordance with the approved grant application, budgets, supporting documents, and all other representations made in support of the approved grant application.

Notice of Grant Award

250 E Street SW, Suite 300
Washington, DC 20525-0001
(202) 606-5000

Foster Grandparent Program

Grantee

City of Santa Fe
200 Lincoln Ave Santa Fe NM 87504-1904

EIN: 856000168
UEI: QLN2YKMMJ8X6
DUNS: 069420818

Award Information

Agreement No.:	20SFWNM006	Performance Period:	07/01/2020 - 06/30/2023
Amendment No.:	4	Budget Period:	07/01/2022 - 06/30/2023
CFDA No.:		Grant Year:	3

Corporation for National and Community Service:

Stacy A Bishop 05/23/2022

Signature Award Date

City of Santa Fe
Legal Applicant

Stacy Bishop
Senior Grants Officer

Anya Alarid
Project Director

Daisy Gallardo, 202-815-4248
Grants Officer

Eugene Rinaldi
Certifying Official/Executive Officer

Daisy Gallardo, 202-815-4248
Program Officer

Santa Fe FGP

City of Santa Fe

Application ID: 22SF244886

Budget Dates: 07/01/2020 - 06/30/2023

		Total Amt	CNCS Share	Grantee Share	Excess Amount
Section I. Volunteer Support Expenses					
A. Project Personnel Expenses		110,622	6,000	104,622	0
B. Personnel Fringe Benefits		4,629	0	4,629	0
FICA		8,463	1,642	6,821	0
Health Insurance		24,141	5,600	18,541	0
Retirement		24,566	1,800	22,766	0
Life Insurance		0	0	0	0
	Total	$61,799	$9,042	$52,757	$0
C. Project Staff Travel					
Local Travel		350	0	350	0
Long Distance Travel					
	Total	$350	$0	$350	$0
D. Equipment					
E. Supplies		2,010	0	2,010	0
F. Contractual and Consultant Services					
I. Other Volunteer Support Costs		2,526	0	2,526	0
Criminal Background Check		282	0	282	0
	Total	$2,808	$0	$2,808	$0
J. Indirect Costs					
Section I. Subtotal		**$177,589**	**$15,042**	**$162,547**	**$0**
Section II. Volunteer Expenses					
A. Stipends					
Corporation Funded		16,445	16,445	0	0
Non-Corporation Funded		43,848	0	43,848	0
Non-Stipended					
	Total	$60,293	$16,445	$43,848	$0
B. Other Volunteer Costs		2,198	0	2,198	0
Meals		900	0	900	0
Uniforms		1,000	0	1,000	0
Insurance		202	0	202	0
Recognition		1,600	0	1,600	0
Volunteer Travel		5,350	1,200	4,150	0
Physical Examinations		0	0	0	0
	Total	$11,250	$1,200	$10,050	$0
Section II. Subtotal		**$71,543**	**$17,645**	**$53,898**	**$0**
Budget Totals		**$249,132**	**$32,687**	**$216,445**	**$0**
Funding Percentages			**13.1%**	**86.9%**	
Required Match			**10%**		
# of years Receiving CNCS Funds			**20**		

FY 2022 GENERAL GRANT AND COOPERATIVE AGREEMENT TERMS AND CONDITIONS

By accepting funds under this award from AmeriCorps[1], the recipient agrees to comply with, and include in all awards and subawards, these General Terms and Conditions, the program-specific terms and conditions, all applicable Federal statutes, regulations and guidelines, and any amendments thereto. The recipient agrees to operate the funded program in accordance with the approved application and budget, supporting documents, and other representations made in support of the approved application. The term recipient is used to connote either recipient or subrecipient, as appropriate, throughout these General Terms and Conditions.

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[1] AmeriCorps is the operating name for the Corporation for National and Community Service

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I. MAJOR CHANGES FROM THE 2021 GENERAL TERMS AND CONDITIONS

A. Preamble: removed COVID-19 Frequently Asked Questions (FAQ) reference.
B. Section F: updated National Service Criminal History Check requirements based on new rule effective May 1, 2021.
C. Updated to reflect changes to the Uniform Guidance published in August 2020.
D. Replaced references to the Improper Payments Elimination and Recovery Improvement Act with the Payment Integrity Information Act of 2019.
E. Removed section on Grantee Procurement.

II. GOVERNING AUTHORITIES

A. LEGISLATIVE AND REGULATORY AUTHORITY

This award is authorized by and subject to The National and Community Service Act of 1990, as amended, (42 U.S.C. 12501 *et seq.*) (NCSA) and/or the Domestic Volunteer Service Act of 1973, as amended, (42 U.S.C. 4950 *et seq.*) (DVSA), the Federal Grant and Cooperative Agreement Act (FGCAA), 31 U.S.C. §§6301-6308, and AmeriCorps' implementing regulations in 45 CFR Chapter XII and/or XXV. Recipients must comply with the requirements of the NCSA and/or DVSA and AmeriCorps' implementing regulations, as applicable.

B. OTHER APPLICABLE TERMS AND CONDITIONS

This award is subject to the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards located at 2 CFR Part 200 and the agency's implementing regulation at 2 CFR Part 2205 (hereinafter, the Uniform Guidance). Award recipients must read, understand, and implement these federal regulations. 2 CFR Part 200, and the August 2020 amendments thereto are incorporated into these terms and conditions by reference.

The recipient must comply with all other applicable statutes, executive orders, regulations, and policies governing the award, including, but not limited to, those included in 2 CFR Chapter I, as

well as those cited in these General Terms and Conditions and Program-Specific Terms and Conditions, and the Assurances and Certifications. Some of these requirements are discussed in these General Terms and Conditions to provide emphasis or additional explanations to recipients. Other provisions are included in these AmeriCorps' General Terms and Conditions because they are required by specific laws or regulations.

In addition to the applicable statutes and regulations referred to above, the recipient must comply with and perform its award consistent with the requirements stated in:

1. The Notice of Grant Award and Signature Page;
2. These General Terms and Conditions;
3. The Program-Specific Terms and Conditions;
4. The Notice of Funding Availability;
5. The recipient's approved application (including the final approved budget, attachments, and pre-award negotiations); and
6. Grant Certification and Assurances.

C. ORDER OF PRECEDENCE

Any inconsistency in the authorities governing the Award shall be resolved by giving precedence in the following order: (a) applicable Federal statutes, (b) applicable Federal regulations, (c) Notice of Grant Award and Signature Page; (d) AmeriCorps Program Specific Terms and Conditions, (e) AmeriCorps General Terms and Conditions, (f) the Notice of Funding Opportunity, and (g) the approved Award Application including all assurances, certifications, attachments, and pre-award negotiations.

III. GENERAL TERMS AND CONDITIONS

A. RESPONSIBILITIES UNDER AWARD ADMINISTRATION

1. **Accountability of the Recipient.** The recipient has full fiscal and programmatic responsibility for managing all aspects of the award and award-supported activities, subject to the oversight of AmeriCorps. The recipient is accountable to AmeriCorps for its operation of the program and the use of AmeriCorps award funds. The recipient must expend award funds in a manner consistent with the cost principles in 2 CFR and in a reasonable manner, and it must record accurately the service activities and outcomes achieved under the award. Although recipients are encouraged to seek the advice and opinion of AmeriCorps on special problems that may arise, such advice does not diminish the recipient's responsibility for making sound judgments and does not shift the responsibility for operating decisions to AmeriCorps.

2. **Subawards.** If authorized by law and permitted by AmeriCorps, a recipient may make subawards in accordance with the requirements set forth in the Uniform Guidance. The recipient must have and implement a plan for oversight and monitoring that complies with the requirements applicable to pass through entities identified at 2 CFR § 200.332 to ensure that each subrecipient has agreed to comply, and is complying, with award requirements.

A recipient of a Federal award that is a pass-through entity has certain obligations to its subrecipients. Those requirements are located at 2 CFR §200.208, § 200.332, § 200.339, and 2 CFR Part 200 Subpart F.

3. **Notice to AmeriCorps.** The recipient will notify the appropriate AmeriCorps Portfolio Manager immediately of any developments or delays that have a significant impact on funded activities, any significant problems relating to the administrative or financial aspects of the award, or any suspected misconduct or malfeasance related to the award or recipient. The recipient will inform the AmeriCorps Portfolio Manager about the corrective action taken or contemplated by the recipient and any assistance needed to resolve the situation. Recipients must also ensure that they comply with the mandatory reporting requirements for suspected criminal activity or fraud, waste or abuse as specified in section III. I.

B. FINANCIAL MANAGEMENT STANDARDS

1. **General.** The recipient must maintain financial management systems that comply with 2 CFR § 200.302(b). The recipient's financial management systems must be capable of distinguishing expenditures attributable to this award from expenditures not attributable to this award. The systems must be able to identify costs by program year and by budget category, and to differentiate between direct and indirect costs. For all recipient's financial management requirements and responsibilities, refer to Subparts D and E of 2 CFR Part 200.

2. **Allowability of Costs.** To be allowable under an award, costs must meet the criteria of 2 CFR § 200.403, which provides that costs must be necessary and reasonable for the performance of the award, must conform to limitations in the award or 2 CFR Part 200 as to types or amounts of cost items, must be consistent with policies and procedures that apply uniformly to both Federally financed and other activities of the recipient, must be adequately documented, and must not be included as a cost or used to meet cost share or matching requirements of any other Federally financed program. Furthermore, the costs must be accorded consistent treatment in like circumstances as either direct or indirect costs in order to avoid the double charging of Federal awards (see 2 CFR § 200.403(d) and § 200.412).

3. **Cost Reporting.** Recipients will be reporting their Federal cash disbursements quarterly through the Payment Management System (PMS) at the Department of Health and Human Services and their Federal share of grant program expenditures (including indirect costs) semi- annually through AmeriCorps' eGrants system. Recipient's financial management systems must be able to routinely produce reports which support and reconcile to the amounts reported to PMS and eGrants. As part of closing out individual awards, recipients must submit a quarterly report to PMS and ensure it reconciles to the drawn amount and FFR in eGrants as applicable within 120 days of the end of the project period. Recipients must also ensure that the financial management systems of any subrecipients can routinely produce the same reports. *As part of its ongoing fiscal oversight of recipients, AmeriCorps*

may randomly select recipients to provide reports supporting their Federal cash disbursements reported to PMS (including supporting information for cash disbursements made by subrecipients). AmeriCorps expects recipients' and subrecipients' financial management systems to be able to produce those supporting reports on a routine basis.

4. **Audits.** Recipient organizations that expend $750,000 or more in total Federal awards in a fiscal year shall have a single or program-specific audit conducted for that year in accordance with the Single Audit Act, as amended, 31 U.S.C. 7501, et seq., and 2 CFR Part 200, Subpart F. If the recipient expends Federal awards under only one Federal program, it may elect to have a program specific audit, if it is otherwise eligible. A recipient that does not expend $750,000 in Federal awards is exempt from the audit requirements for that year. However, it must continue to conduct financial management reviews of its subrecipients, and its records and its subrecipients' records must be available for review and audit in accordance with 2 CFR §§ 200.334-200.338 and §200.332(a)(5). Additionally, a recipient acting as a pass-through entity must issue management decisions for audit findings pertaining to the Federal award provided to the subrecipient as required by 2 CFR § 200.521 and ensure follow-up on audit findings in a timely manner to ensure that the subrecipient corrects any deficiencies identified in the audit.

C. CHANGES IN BUDGET OR KEY PERSONNEL

All budget and programmatic changes must comply with 2 CFR § 200.308 – Revision of budget and program plans. 2 CFR § 200.407 Prior written approval (prior approval) – provides an exhaustive list of those other items requiring AmeriCorps' advance approval.

D. BANKRUPTCY

The recipient must notify AmeriCorps if, during the term of its award, the recipient or one of its subrecipients becomes insolvent or is unable to pay its debts as they mature, or files a voluntary petition in bankruptcy or is the subject of an involuntary petition that is neither stayed nor dismissed within 60 days after the petition is filed.

E. PROHIBITED PROGRAM ACTIVITIES

The recipient must comply with, and require all subrecipients to comply with, the prohibitions on use of AmeriCorps funds applicable to their program as identified in sections 132A and 174 of the NCSA (42 U.S.C. §§ 12584a and 12634) and section 403 of the DVSA (42 U.S.C. § 5043), and provisions by Congress in annual appropriations acts. More specific guidance on these prohibitions will be provided in AmeriCorps' Program Specific Terms and Conditions and in other guidance.

F. NATIONAL SERVICE CRIMINAL HISTORY CHECK REQUIREMENTS

The National Service Criminal History Check (NSCHC) is a screening procedure established by law to protect the beneficiaries of national service. On February 24, 2021, AmeriCorps published a new NSCHC regulation that went into effect May 1, 2021. See 45 CFR §§ 2540.200-2540.207 and https://americorps.gov/grantees-sponsors/history-check for complete information and FAQs. The law requires recipients to conduct and document NSCHCs on any person (including award-funded staff, national service participant, or volunteer) receiving a salary, living allowance, stipend or education award through a program receiving AmeriCorps funds. The NSCHC must be conducted, reviewed, and an eligibility determination made by the grant recipient based on the results of the NSCHC no later than the day before a person begins to work or serve on an NSCHC-required grant. An individual is ineligible to serve in a position that receives such AmeriCorps funding if the individual is registered, or required to be registered, as a sex offender or has been convicted of murder. The cost of conducting NSCHCs is an allowable expense under the award.

Unless AmeriCorps has provided a recipient with a written waiver, recipients must perform the following checks:

All award-funded staff, national service participants, and volunteers must undergo NSCHCs that include:

1. A nationwide name-based search of the National Sex Offender Public Website (NSOPW) through NSOPW.gov; and
2. A name- or fingerprint-based check of the state criminal history record repository or agency-designated alternative for the person's state of residence and state where the person will serve/work; and
3. A fingerprint-based FBI criminal history check through the state criminal history record repository or agency-approved vendor.

You must retain adequate documentation that you completed the required NSCHC. Inability to demonstrate that you conducted a required criminal history check component, to include the NSOPW, as specified in the regulations, may result in sanctions which may include disallowance of costs.

G. THE OFFICE OF INSPECTOR GENERAL

AmeriCorps' Office of Inspector General (OIG) conducts and supervises independent audits, evaluations, and investigations of AmeriCorps' programs and operations. Based on the results of these audits, reviews, and investigations, the OIG recommends disallowing costs and also recommends amending or adding policies to promote economy and efficiency and to prevent and detect fraud, waste, and abuse in AmeriCorps' programs and operations.

The OIG conducts and supervises audits of AmeriCorps recipients, as well as legally required audits and reviews. The legally required audits include evaluating AmeriCorps' compliance with the Payment Integrity Information Act of 2019, which may result in grantees being requested to

produce responsive documentation. The OIG uses a risk-based approach, along with input received from AmeriCorps management, to select recipients and awards for audit. The OIG hires independent audit firms to conduct some of its audits. The OIG audit staff is available to discuss any audit and can be reached at (202) 606-9390.

Recipients must cooperate fully with AmeriCorps requests for documentation and OIG inquiries by timely disclosing complete and accurate information pertaining to matters under investigation, audit or review, and by not concealing information or obstructing audits, inspections, investigations, or other official inquiries.

H. RECOGNITION OF AMERICORPS SUPPORT

1. **General Statement**. Recipients and subrecipients of federal agency AmeriCorps assistance or resources shall identify their programs, projects or initiatives as AmeriCorps or AmeriCorps Seniors programs or projects accordingly. All agreements with subrecipients, operating sites, or service locations, related to AmeriCorps programs and initiatives must explicitly state that the program is an AmeriCorps or AmeriCorps Seniors program.

   Similarly, recipients and subrecipients shall identify all national service members or volunteers serving at their programs, projects or initiatives as either AmeriCorps members, AmeriCorps Seniors volunteers, Day of Service volunteers or where appropriate for Volunteer Generation Fund simply "volunteers."

2. **Visual Representations and Prominent Display**. Recipients shall identify their programs, projects, or initiatives, and their members or volunteers, through the use of visual representations, including: logos; insignias; written acknowledgements, publications and other written materials; websites and social media platforms; and service gear such as clothing. All visual representations must follow current AmeriCorps branding guidelines, which include proper logo use and cobranding requirements. To provide recipients technical assistance in ensuring compliance with proper logo use and cobranding requirements, AmeriCorps provides brand guidelines, to which recipients and subrecipients should refer and follow. The brand guidelines are available at www.americorps.gov/brand-resources.

   All recipient and subrecipient websites and social media communications shall clearly state, as appropriate, that they are an AmeriCorps recipient or funded by a grant from AmeriCorps and shall prominently display the AmeriCorps or AmeriCorps Seniors logo. Recipients and subrecipients shall prominently display the AmeriCorps, AmeriCorps Seniors, or appropriate AmeriCorps Day of Service name and logo on all service gear and public materials, in accordance with AmeriCorps' requirements. Public materials are defined in the branding toolkit.

3. **Acknowledgement and Disclaimer on Published Materials.** The appropriate AmeriCorps or AmeriCorps Seniors logo shall be included on publications related to an award of AmeriCorps assistance or resources. An acknowledgement and disclaimer shall be displayed on all reports and other published materials based upon work supported by the

award. The acknowledgement and disclaimer may contain language the same as or similar to:

This material is based upon work supported by AmeriCorps under Grant No(s) [ ]. Opinions or points of view expressed in this document are those of the authors and do not necessarily reflect the official position of, or a position that is endorsed by, AmeriCorps."

4. **Brand Identification Through Publicity.** Recipients shall provide information or training to their AmeriCorps members, AmeriCorps Seniors volunteers, Day of Service volunteers, or Volunteer Generation Fund volunteers about how their programs, projects or initiatives are part of AmeriCorps. Recipients are strongly encouraged to place signs that include the AmeriCorps or AmeriCorps Seniors name and logo, or the appropriate AmeriCorps version of the Day of Service logo at all their service sites and may use the slogan "AmeriCorps Serving Here" or "AmeriCorps Seniors Serving Here," as appropriate. When AmeriCorps members and programs or AmeriCorps Seniors volunteers and programs are publicized – including but not limited to public speaking opportunities, press releases, news stories, blog posts, websites, social media posts, online videos, public service announcements, paid advertising, brochures and other communications channels – individuals must be identified as AmeriCorps members or AmeriCorps Seniors volunteers, while programs should be identified as AmeriCorps or AmeriCorps Seniors programs or projects and, where possible, appropriate logos must be displayed.

5. **Alteration of Brand Identities Prohibited Without AmeriCorps Written Permission.** Recipients may not alter the AmeriCorps or AmeriCorps Seniors logos or other AmeriCorps branding and must obtain written permission from AmeriCorps before using the AmeriCorps name or logo, or the AmeriCorps Seniors name or logo on materials that will be sold. Recipients must also obtain written permission from AmeriCorps before permitting donors to use the AmeriCorps name or logo, or the AmeriCorps Seniors name or logo in promotional materials.

6. **Prohibited Use or Display of Names and Logos for Certain Activities.** The recipient or subrecipient may not use or display the AmeriCorps name or logo, or the AmeriCorps Seniors name or logo in connection with any activity prohibited by statute or regulation, including any political activities.

I. REPORTING OF FRAUD, WASTE, AND ABUSE

Recipients must contact the OIG ***and*** their Portfolio Manager ***without delay*** when they ***first suspect***:

1. Any criminal activity or violations of law has occurred, such as:
    - Fraud, theft, conversion, misappropriation, embezzlement, or misuse of funds or property by any person, including AmeriCorps personnel, grantees, or contractors—even if no federal funds or property was involved;
    - Submission of a false claim or a false statement by any person in connection with any AmeriCorps program, activity, grant or operations;

- Concealment, forgery, falsification, or unauthorized destruction of government or program records;
- Corruption, bribery, kickbacks, acceptance of illegal gratuities, extortion, or conflicts of interest in connection with operations, programs, activities, contracts, or grants;
- Other misconduct in connection with operations, programs, activities, contracts, or grants; or
- Mismanagement, abuse of authority, or other misconduct by AmeriCorps personnel.

2. Fraud, waste, or abuse.
   - Fraud occurs when someone is intentionally dishonest or uses intentional misrepresentation or misleading omission to receive something of value or to deprive someone, including the government, of something of value.
   - Waste occurs when taxpayers do not receive reasonable value for their money in connection with a government-funded activity due to an inappropriate act or omission by people with control over or access to government resources.
   - Abuse is behavior that is deficient, objectively unreasonable, or improper under the circumstances. Abuse also includes the misuse of authority or position for personal financial gain or the gain of an immediate or close family member or business associate.

The OIG maintains a hotline to receive this information, which can be reached by email at hotline@cncsoig.gov or by telephone at (800) 452-8210. Upon request, OIG will take appropriate measures to protect the identity of any individual who reports misconduct, as authorized by the Inspector General Act of 1978, as amended. Reports to OIG may also be made anonymously.

The recipient should take no further steps to investigate suspected misconduct, except as directed by the OIG or to prevent the destruction of evidence or information.

J. WHISTLEBLOWER PROTECTION

1. This award and employees working on this award will be subject to the whistleblower rights and remedies in the pilot program on Contractor employee whistleblower protections established at 41 U.S.C. 4712 by section 828 of the National Defense Authorization Act for Fiscal Year 2013 (Pub. L. 112-239).

2. An employee of a recipient may not be discharged, demoted, or otherwise discriminated against as a reprisal for disclosing information that the employee reasonably believes is evidence of gross mismanagement of a Federal contract or award, a gross waste of Federal funds, an abuse of authority (an arbitrary and capricious exercise of authority that is inconsistent with the mission of AmeriCorps or the successful performance of a contract or award of AmeriCorps) relating to a Federal contract or award, a substantial and specific

danger to public health or safety, or a violation of law, rule, or regulation related to a Federal contract (including the competition for or negotiation of a contract) or award.

3. The recipient shall inform its employees and contractors in writing, in the predominant language of the workforce or organization, of employee whistleblower rights and protections under 41 U.S.C. 4712, as described above and at http://www.cncsoig.gov/whistleblower-protection.

K. LIABILITY AND SAFETY ISSUES

The recipient must institute safeguards as necessary and appropriate to ensure the safety of members and volunteers. Members and volunteers may not participate in projects that pose undue safety risks. Any insurance costs under the award must comply with 2 CFR § 200.447, which outlines what insurance costs are allowable.

L. AWARD MONITORING

1. **Site visits**. AmeriCorps may make site visits to review and evaluate recipient records, accomplishments, organizational procedures and financial control systems; to conduct interviews; and to provide technical assistance as necessary.

2. **Desk reviews.** AmeriCorps may conduct desk reviews to make limited verifications of recipient compliance with the terms of their award, conduct a review of the recipient's general management practices, and identify any practice or procedure that may require further scrutiny.

3. **Responding to information requests.** Pursuant to 2 CFR 200.337, AmeriCorps may request documentation from recipients in order to monitor the award or to comply with other legal requirements, such as the Payment Integrity Information Act of 2019. ***Failure to make timely responses to such requests may result in award funds being placed on temporary manual hold, reimbursement only, or other remedies as appropriate.***

M. NON-DISCRIMINATION PUBLIC NOTICE AND RECORDS COMPLIANCE

1. **Public Notice of Non-discrimination**. The recipient must notify members, community beneficiaries, applicants, program staff, and the public, including those with impaired vision or hearing, that it operates its program or activity subject to the non-discrimination requirements applicable to their program found at §§ 175 and 176(f) of the NCSA or § 417 of the DVSA, and relevant program regulations found at 45 CFR Parts 2540 (AmeriCorps State and National), 2551 (Senior Companion Program), 2552 (Foster Grandparent Program), 2553 (RSVP), and 2556 (AmeriCorps VISTA). The notice must summarize the requirements, note the availability of compliance information from the recipient and AmeriCorps, and briefly explain procedures for filing discrimination complaints with AmeriCorps.

Sample language is:

Any benefits and terms and conditions of this program, are available to all without regard to race, color, national origin, gender, age, religion, sexual orientation, disability, gender identity or expression, political affiliation, marital or parental status, genetic information and military service. [Grantee's name] policy and federal law prohibits reprisal for engaging in protected activity (reporting discrimination or harassment, participating in investigations of such allegations, or intervening to assist those who are subjected to prohibited behaviors), and it will not be tolerated. In addition to filing a complaint with local and state agencies that are responsible for resolving discrimination complaints, you may bring a complaint to the attention of the Corporation for National and Community Service. If you believe that you or others have been discriminated against, or if you want to seek advice, contact:

(Name, address, phone number – both voice and TTY, and preferably toll free – FAX number and email address of the recipient) or
Equal Employment Opportunity Office (EEOP)
AmeriCorps
250 E Street, SW
Washington, DC 20525
(202) 606-7503
eo@cns.gov (email)

The recipient must include information on civil rights requirements, complaint procedures and the rights of beneficiaries in member or volunteer service agreements, handbooks, manuals, pamphlets, and post in prominent locations, as appropriate. The recipient must also notify the public in recruitment material and application forms that it operates its program or activity subject to the nondiscrimination requirements. Sample language, in bold print, is: **This program is available to all, without regard to race, color, national origin, gender, age, religion, sexual orientation, disability, gender identity or expression, political affiliation, marital or parental status, genetic information and military service.** Where a significant portion of the population eligible to be served needs services or information in a language other than English, the recipient shall take reasonable steps to provide written material of the type ordinarily available to the public in appropriate languages.

2. **Prohibition Against National Origin Discrimination Affecting Limited English Proficient (LEP) Persons.** Pursuant to Executive Order (EO) 13166 – Improving Access to Services for Persons with Limited English Proficiency, recipients are required to provide meaningful access to their programs and activities by LEP persons. For more information, please see the policy guidance at 67 FR 64604.

3. **Records and Compliance Information.** The recipient must keep records and make available to AmeriCorps timely, complete, and accurate compliance information to allow

AmeriCorps to determine if the recipient is complying with the civil rights statutes and implementing regulations. Where a recipient extends Federal financial assistance to subrecipients, the subrecipients must make available compliance information to the recipient so it can carry out its civil rights obligations in accordance with the records requirements at 2 CFR §§ 200.334-200.338 and § 200.331(a)(5).

4. **Obligation to Cooperate.** The recipient must cooperate with AmeriCorps so that AmeriCorps can ensure compliance with the civil rights statutes and implementing regulations. The recipient shall permit access by AmeriCorps during normal business hours to its books, records, accounts, staff, members or volunteers, facilities, and other sources of information as may be needed to determine compliance.

N. IDENTIFICATION OF FUNDING

When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with Federal money, all grantees receiving AmeriCorps funds included, shall clearly state— (1) the percentage of the total costs of the program or project which will be financed with Federal money; (2) the dollar amount of Federal funds for the project or program; and (3) the percentage and dollar amount of the total costs of the project or program that will be financed by non-governmental sources.

O. AWARD PRODUCTS

1. **Sharing Award Products.** To the extent practicable, the recipient agrees to make products produced under the award available at the cost of reproduction to others in the field.

2. **Acknowledgment of Support.** Publications created by members, volunteers or award-funded staff must be consistent with the purposes of the award. The appropriate program AmeriCorps logo shall be included on such documents. The recipient is responsible for assuring that the following acknowledgment and disclaimer appears in any external report or publication of material based upon work supported by this award:

   "This material is based upon work supported by AmeriCorps, the operating name of the Corporation for National and Community Service, *under Grant No.__. Opinions or points of view expressed in this document are those of the authors and do not necessarily reflect the official position of, or a position that is endorsed by, AmeriCorps or [the relevant AmeriCorps Program]."*

P. SUSPENSION OR TERMINATION OF AWARD

AmeriCorps may suspend or terminate this award in accordance with 2 CFR §§ 200. 200.339 and 200.340 (85 FR 49506, 49559-60) such as applicable AmeriCorps regulations and statutes. In addition, a recipient may suspend or terminate assistance to one of its subrecipients in accordance with 2 CFR §§ 200.339 and 200.340, provided that such action complies with 2 CFR § 200.341. 2 CFR § 200.340(a)(2) prohibits arbitrary termination of grant awards by

AmeriCorps. As before the clarifications to 2 CFR Part 200, AmeriCorps may initiate termination for cause, or when (based on new evidence) there is a significant question about the feasibility or effectiveness of the intended objective of the award.

Q. TRAFFICKING IN PERSONS

This award is subject to requirements of Section 106(g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. § 7104).

1. Provisions applicable to a recipient that is a private entity.
   a. You as the recipient, your employees, subrecipients under this award, and subrecipients' employees may not:
      i. Engage in severe forms of trafficking in persons during the period of time that the award is in effect;
      ii. Procure a commercial sex act during the period of time that the award is in effect; or
      iii. Use forced labor in the performance of the award or subawards under the award.
   b. We as the Federal awarding agency may unilaterally terminate this award, without penalty, if you or a subrecipient that is a private entity
      i. Violates a prohibition in paragraph (a.) of this award term; or
      ii. Has an employee who violates a prohibition in paragraph (a.) of this award term through conduct that is either:
         (A.) Associated with performance under this award; or
         (B.) Imputed to you or the subrecipient using the standards and due process for imputing the conduct of an individual to an organization that are provided in 2 CFR Part 180, "OMB guidelines to Agencies on Government-wide Debarment and Suspension (Nonprocurement)," as implemented by our agency at 2 CFR Part 2200.

2. Provisions applicable to a recipient other than a private entity. We as the Federal awarding agency may unilaterally terminate this award, without penalty, if a subrecipient that is not a private entity–
   a. Is determined to have violated an applicable prohibition of paragraph (1)(a.) of this award term; or
   b. Has an employee who is determined by the agency official authorized to terminate the award to have violated an applicable prohibition in paragraph (1)(a)(i) of this award term through conduct that is –
      i. Associated with performance under this award; or
      ii. Imputed to you using the standards and due process for imputing conduct of an individual to an organization that are provided in 2 CFR Part 180, "OMB Guidelines to Agencies on Government-wide Debarment and Suspension (Nonprocurement)," as implemented by our agency at 2 CFR Part 2200.

3. Provisions applicable to any recipient.

a. You must inform us immediately of any information you receive from any source alleging a violation of a prohibition in paragraph (1)(a) of this award term.

b. Our right to terminate unilaterally that is described in paragraph (1) and (2) of this section:

   i. Implements section 106(g) of the Trafficking Victims Protection Act of 2000
   (TVPA), as amended (22 U.S.C. 7104(g)), and

   ii. Is in addition to all other remedies for noncompliance that are available to us under this award.

c. You must include the requirements of paragraph (1)(a) of this award term in any subaward you make to a private entity.

4. Definitions. For purposes of this award term:

a. "Employee" means either:

   i. An individual employed by you or a subrecipient who is engaged in the performance of the project or program under this award; or

   ii. Another person engaged in the performance of the project or program under this award and not compensated by you including, but not limited to, a volunteer or individual whose service are contributed by a third party as an in-kind contribution toward cost sharing or matching requirements.

b. "Forced labor" means labor obtained by any of the following methods: the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

c. "Private entity":

   i. Means any entity other than a State, local government, Indian tribe, or foreign public entity, as those terms are defined in 2 CFR §175.25.

   ii. Includes:

      (a.) A nonprofit organization, including any non-profit institution of higher education, hospital, or tribal organization other than one included in the definition of Indian tribe at 2 CFR § 175.25(b).

      (b.) A for-profit organization.

d. "Severe forms of trafficking in persons," "commercial sex act," and "coercion" have the meanings given at section 103 of the TVPA, as amended (22 U.S.C. § 7102).

R. SYSTEM OF AWARD MANAGEMENT (SAM) and UNIVERSAL IDENTIFIER REQUIREMENTS (Required provision under 2 CFR § 25.220)

1. Requirement for Central Contractor Registration (CCR): Unless you are exempted from this requirement under 2 CFR § 25.110, you as the recipient must maintain the currency of your information in the SAM until you submit the final financial report required under this award or receive the final payment, whichever is later. This requires that you review and update the information at least annually after the initial registration, and more frequently if required by changes in your information or another award term.

2. Requirement for Unique Entity Identifier: If you are authorized to make subawards under this award, you:
   a. Must notify potential subrecipients that no entity (see definition in paragraph c of this award term) may receive a subaward from you unless the entity has provided its unique entity identifier to you. *(AmeriCorps' eGrants system requires a DUNS number.)*
   b. May not make a subaward to an entity unless the entity has provided its unique entity identifier to you.

3. Definitions. For purposes of this award term:
   a. System of Award Management (SAM) means the Federal repository into which an entity must provide information required for the conduct of business as a recipient. Additional information about registration procedures may be found at the SAM Internet site (currently at https://sam.gov/content/home).
   b. Unique Entity Identifier means the identifier required for SAM registration to uniquely identify business entities. (AmeriCorps' eGrants system currently requires DUNs numbers. DUNs stands for Data Universal Numbering System (DUNS) number a nine-digit number established and assigned by Dun and Bradstreet, Inc. (D&B) to uniquely identify business entities. A DUNS number may be obtained from D&B by telephone (currently 866- 7055711) or the Internet (currently at http://fedgov.dnb.com/webform).
   a. Entity, as it is used in this award term, means all of the following, as defined at 2 CFR part 25, subpart C:
      i. A Governmental organization, which is a State, local government, or Indian Tribe;
      ii. A foreign public entity;
      iii. A domestic or foreign nonprofit organization;
      iv. A domestic or foreign for-profit organization; and
      v. A Federal agency, but only as a subrecipient under an award or subaward to a non-Federal entity.
   b. Subaward:
      i. This term means a legal instrument to provide support for the performance of any portion of the substantive project or program for which you received this award and that you as the recipient award to an eligible subrecipient.

ii. The term does not include your procurement of property and services needed to carry out the project or program (for further explanation, see 2 CFR § 200.330.

iii. A subaward may be provided through any legal agreement, including an agreement that you consider a contract.

c. Subrecipient means an entity that:

i. Receives a subaward from you under this award; and

ii. Is accountable to you for the use of the Federal funds provided by the subaward.

S. TRANSPARENCY ACT REQUIREMENTS (for Grants and Cooperative Agreements of $30,000 or More)

Reporting Subawards and Executive Compensation:

1. Reporting of first-tier subawards.

a. Applicability. Unless you are exempt as provided in paragraph 4, of this award term (below), you must report each action that obligates $30,000 or more in Federal funds that does not include Recovery funds (as defined in section 1512(a)(2) of the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5) for a subaward to an entity (see definitions in paragraph 5. of this award term).

b. Where and when to report.

i. You must report each obligating action described in paragraph 1.a. of this award term to http://www.fsrs.gov.

ii. For subaward information, report no later than the end of the month following the month in which the obligation was made. (For example, if the obligation was made on November 7th in a given year, the obligation must be reported by no later than the end of December.)

c. What to report. You must report the information about each obligating action that the submission instructions posted at http://www.fsrs.gov specify.

2. Reporting Total Compensation of Recipient Executives.

a. Applicability and what to report. You must report total compensation for each of your five most highly compensated executives for the preceding completed fiscal year, if--

i. The total Federal funding authorized to date under this award is $30,000 or more;

ii. In the preceding fiscal year, you received--

(a.) 80 percent or more of your annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR § 170.320 (and subawards); and

(b.) $25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR § 170.320 (and subawards); and

iii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. §§ 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at http://www.sec.gov/answers/execomp.htm.)

b. Where and when to report. You must report executive total compensation described in paragraph (2.)(a.) of this award term:

i. As part of your registration profile at https://www.sam.gov/portal/public/SAM/.

ii. By the end of the month following the month in which this award is made, and annually thereafter.

3. Reporting of Total Compensation of Subrecipient Executives.

a. Applicability and what to report. Unless you are exempt as provided in paragraph 4. of this award term, for each first-tier subrecipient under this award, you shall report the names and total compensation of each of the subrecipient's five most highly compensated executives for the subrecipient's preceding completed fiscal year, if--

i. In the subrecipient's preceding fiscal year, the subrecipient received--

(a.) 80 percent or more of its annual gross revenues fromFederal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR §170.320 (and subawards); and

(b.) $25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts), and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR §170.320 (and subawards); and

ii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. §§ 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at http://www.sec.gov/answers/execomp.htm.)

b. Where and when to report. You must report subrecipient executive total compensation described in paragraph 3.a. of this award term:

i. To the recipient.

ii. By the end of the month following the month during which you make the subaward. For example, if a subaward is obligated on any date during the month of October of a given year (i.e., between October 1 and 31), you must report any required compensation information of the subrecipient by November 30 of that year.

4. Exemptions. If, in the previous tax year, you had gross income, from all sources, under $300,000, you are exempt from the requirements to report:
   a. Subawards, and
   b. The total compensation of the five most highly compensated executives of any subrecipient.

5. Definitions. For purposes of this award term:
   a. Entity means all of the following, as defined in 2 CFR Part 25:
      i. A Governmental organization, which is a State, local government, or Indian tribe;
      ii. A foreign public entity;
      iii. A domestic or foreign nonprofit organization;
      iv. A domestic or foreign for-profit organization;
      v. A Federal agency, but only as a subrecipient under an award or subaward to a non- Federal entity.
   b. Executive means officers, managing partners, or any other employees in management positions.
   c. Subaward:
      i. This term means a legal instrument to provide support for the performance of any portion of the substantive project or program for which you received this award and that you as the recipient award to an eligible subrecipient.
      ii. The term does not include your procurement of property and services needed to
      carry out the project or program (for further explanation, see 2 CFR § 200.331).
      iii. A subaward may be provided through any legal agreement, including an agreement that you or a subrecipient considers a contract.
   d. Subrecipient means an entity that:
      i. Receives a subaward from you (the recipient) under this award; and ii. Is accountable to you for the use of the Federal funds provided by the subaward.
   e. Total compensation means the cash and noncash dollar value earned by the executive during the recipient's or subrecipient's preceding fiscal year and includes the following (for more information see 17 CFR §229.402(c)(2)):
      i. Salary and bonus.
      ii. Awards of stock, stock options, and stock appreciation rights. Use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments.
      iii. Earnings for services under non-equity incentive plans. This does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives, and are available generally to all salaried employees.
      iv. Change in pension value. This is the change in present value of defined benefit and actuarial pension plans.

v. Above-market earnings on deferred compensation which is not tax-qualified.

vi. Other compensation, if the aggregate value of all such other compensation (e.g. severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds $10,000.

T. CONFLICT OF INTEREST

You must disclose in writing any potential conflict of interest to your AmeriCorps Portfolio Manager, or to the pass-through entity if you are a subrecipient or contractor. This disclosure must take place immediately. The AmeriCorps conflict of interest policies apply to subawards as well as contracts, and are as follows:

1. As a non-Federal entity, you must maintain written standards of conduct covering conflicts of interest and governing the performance of your employees engaged in the selection, award, and administration of subawards and contracts.

2. None of your employees may participate in the selection, award, or administration of a subaward or contract supported by a Federal award if he or she has a real or apparent conflict of interest. Such a conflict of interest would arise when the employee, officer, or agent, any member of his or her immediate family, his or her partner, or an organization which employs or is about to employ any of the parties indicated herein, has a financial or other interest in or a tangible personal benefit from an organization considered for a subaward or contract. The officers, employees, and agents of the non-Federal entity must neither solicit nor accept gratuities, favors, or anything of monetary value from subrecipients or contractors or parties to subawards or contracts.

3. If you have a parent, affiliate, or subsidiary organization that is not a State, local government, or Indian tribe, you must also maintain written standards of conduct covering organizational conflicts of interest. Organizational conflicts of interest mean that because of relationships with a parent company, affiliate, or subsidiary organization, you are unable or appear to be unable to be impartial in conducting a subaward or procurement action involving a related organization.

U. AWARD TERM AND CONDITION FOR RECIPIENT INTEGRITY AND PERFORMANCE MATTERS (Required provision under 2 CFR § 200.210(b)(iii) for grants and cooperative agreements of $500,000 or more)

1. General Reporting Requirement

If the total value of your currently active grants, cooperative agreements, and procurement contracts from all Federal awarding agencies exceeds $10,000,000 for any period of time during the period of performance of this Federal award, then you as the recipient during that period of time must maintain the currency of information reported to the System for Award Management (SAM) that is made available in the designated integrity and performance system (currently the

Federal Awardee Performance and Integrity Information System (FAPIIS)) about civil, criminal, or administrative proceedings described in paragraph 2 of this award term and condition. This is a statutory requirement under section 872 of Public Law 110-417, as amended (41 U.S.C. 2313). As required by section 3010 of Public Law 111-212, all information posted in the designated integrity and performance system on or after April 15, 2011, except past performance reviews required for Federal procurement contracts, will be publicly available.

2. Proceedings About Which You Must Report

Submit the information required about each proceeding that:

a. Is in connection with the award or performance of a grant, cooperative agreement, or procurement contract from the Federal Government;

b. Reached its final disposition during the most recent five year period; and

c. Is one of the following:

(1) A criminal proceeding that resulted in a conviction, as defined in paragraph 5 of this award term and condition;

(2) A civil proceeding that resulted in a finding of fault and liability and payment of a monetary fine, penalty, reimbursement, restitution, or damages of $5,000 or more;

(3) An administrative proceeding, as defined in paragraph 5 of this award term and condition, that resulted in a finding of fault and liability and your payment of either a monetary fine or penalty of $5,000 or more or reimbursement, restitution, or damages in excess of $100,000; or

(4) Any other criminal, civil, or administrative proceeding if:

(i) It could have led to an outcome described in paragraph 2.c.(1), (2), or (3) of this award term and condition;

(ii) It had a different disposition arrived at by consent or compromise with an acknowledgment of fault on your part; and

(iii) The requirement in this award term and condition to disclose information about the proceeding does not conflict with applicable laws and regulations.

3. Reporting Procedures

Enter in the SAM Entity Management area the information that SAM requires about each proceeding described in paragraph 2 of this award term and condition. You do not need to submit the information a second time under assistance awards that you received if you already provided the information through SAM because you were required to do so under Federal procurement contracts that you were awarded.

4. Reporting Frequency

During any period of time when you are subject to the requirement in paragraph 1 of this award term and condition, you must report proceedings information through SAM for the most recent five-year period, either to report new information about any proceeding(s) that you have not reported previously or affirm that there is no new information to report. Recipients that have

Federal contract, grant, and cooperative agreement awards with a cumulative total value greater than $10,000,000 must disclose semiannually any information about the criminal, civil, and administrative proceedings.

5. Definitions

For purposes of this award term and condition:

a. Administrative proceeding means a non-judicial process that is adjudicatory in nature in order to make a determination of fault or liability (e.g., Securities and Exchange Commission Administrative proceedings, Civilian Board of Contract Appeals proceedings, and Armed Services Board of Contract Appeals proceedings). This includes proceedings at the Federal and State level but only in connection with performance of a Federal contract or grant. It does not include audits, site visits, corrective plans, or inspection of deliverables.

b. Conviction, for purposes of this award term and condition, means a judgment or conviction of a criminal offense by any court of competent jurisdiction, whether entered upon a verdict or a plea, and includes a conviction entered upon a plea of nolo contendere.

c. Total value of currently active grants, cooperative agreements, and procurement contracts includes—
   (1) Only the Federal share of the funding under any Federal award with a recipient cost share or match; and
   (2) The value of all expected funding increments under a Federal award and options, even if not yet exercised.

V. BREACHES OF PERSONALLY IDENTIFIABLE INFORMATION (PII)

All recipients and subrecipients need to be prepared for potential breaches of Personally Identifiable Information (PII). OMB defines PII as any information about an individual, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, social security number, date and place of birth, mother's maiden name, biometric records, etc., including any other personal information which is linked or linkable to an individual. All recipients and subrecipients must ensure that they have procedures in place to prepare for and respond to breaches of PII, and notify the Federal awarding agency in the event of a breach.

If your AmeriCorps grant-funded program or project creates, collects, uses, processes, stores, maintains, disseminates, discloses, or disposes of PII within the scope of that Federal grant award, or uses or operates a Federal information system, you must establish procedures to prepare for and respond to a potential breach of PII, including notice of a breach of PII to

AmeriCorps. Grantees experiencing a breach should immediately notify AmeriCorps' Office of Information Technology, and the AmeriCorps Portfolio Manager.

IV. ATTACHMENT

https://cnsgov.sharepoint.com/:b:/r/sites/COO/2015%20Policies/Grant%20Program%20Civil%20Rights%20and%20Non-Harassment%20March%202021.pdf?csf=1&web=1&e=vfhBxw

2022 Terms and Conditions for AmeriCorps Seniors Foster Grandparent (FGP) and Senior Companion Programs (SCP)

These AmeriCorps (AmeriCorps is the operating name for the Corporation for National and Community Service) **Grant Program Specific Terms and Conditions and the General Terms and Conditions, are binding on the recipient.**

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I. CHANGES FROM THE 2021 FGP and SCP PROGRAM TERMS AND CONDITIONS

- Section III.H. Added Abortion Services or Referrals to Prohibited Activities.
- Section VIII. A. Added a Progress Report Light.
- Section VIII.C. Emphasized that grantees must submit a quarterly Federal Financial Report (FFR)/Federal Cash Transaction Report to the Dept. of Health and Human Services/Payment Management System (HHS/PMS) as part of the final financial reconciliation of the grant.
- Section XI: Updated the links for the required National Service Criminal History Check Training.

II. AWARD PERIOD AND INCREMENTAL FUNDING

For the purpose of this award, a project period is the complete length of time the recipient is proposed to be funded to complete approved activities under the award. A project period may contain one or more budget periods. A budget period is a specific interval of time for which Federal funds are being provided to fund a recipient's approved activities and budget.

Unless otherwise specified, the award covers a three-year project period. In approving a multi-year project period, AmeriCorps generally makes an initial award for the first year of operation. Additional funding is contingent upon satisfactory performance, a recipient's demonstrated capacity to manage an award and comply with award requirements, and the availability of Congressional appropriations. AmeriCorps reserves the right to adjust the amount of an award or elect not to

continue funding for subsequent years. The project period and the budget period are noted on the award document.

III. PROHIBITION ON USE OF FUNDS

As specified in 42 U.S.C. § 5043(c), as well as in 45 CFR §§ 2551.121 and 2552.121, while charging time to a Senior Companion or Foster Grandparent or Senior program, accumulating service or training hours, or otherwise performing activities supported by the Senior Companion or Foster Grandparent Program or AmeriCorps, staff and volunteers may not engage in the following activities:

A. Political activities.

1. No part of any award shall be used to finance, directly or indirectly, any activity to influence the outcome of any election to public office, or any voter registration activity. No project shall be conducted in a manner involving the use of funds, the provision of services, or the employment or assignment of personnel in a matter supporting or resulting in the identification of such project with:

    a. Any partisan or nonpartisan political activity associated with a candidate, or contending faction or group, in an election; or

    b. Any activity to provide voters or prospective voters with transportation to the polls or similar assistance in connection with any such election; or

    c. Any voter registration activity, except that voter registration applications and nonpartisan voter registration information may be made available to the public at the premises of the sponsor. But, in making registration applications and nonpartisan voter registration information available, employees of the sponsor shall not express preferences or seek to influence decisions concerning any candidate, political party, election issue, or voting decision.

2. Notwithstanding 42 U.S.C. § 5043(c), and 45 CFR §§ 2551.121(a)(3) and 2552.121(a)(3), anti-lobbying language in AmeriCorps's current appropriations legislation (like anti-lobbying language in AmeriCorps's past appropriations legislation) prohibits recipients from using AmeriCorps funds to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

B. Non-displacement of employed workers.

An AmeriCorps Seniors volunteer in the Senior Companion or Foster Grandparent Program shall not perform any service or duty or engage in any activity that would otherwise be performed by an employee of the sponsor, or that would supplant the hiring of, or result in the displacement of employees, or impair existing contracts for services.

C. Compensation for service.

A Senior Companion or Foster Grandparent Program agency or organization to which AmeriCorps Seniors volunteers are assigned, or which operates or supervises any Senior Companion or Foster Grandparent program, shall not request or receive any compensation from AmeriCorps Seniors volunteers or from beneficiaries for services of AmeriCorps Seniors volunteers.

1. The regulations do not prohibit a sponsor from soliciting and accepting voluntary contributions from the community at large to meet its local support obligations under the grant or from entering into agreements with parties other than beneficiaries to support additional volunteers beyond those supported by the AmeriCorps grant.

2. A volunteer station may contribute to the financial support of the Foster Grandparent or Senior Companion Program. However, this support shall not be a required precondition for a potential station to obtain Senior Companion or Foster Grandparent Program services.

3. If a volunteer station agrees to provide funds to support additional AmeriCorps Seniors volunteers, or pay for other volunteer support costs, the agreement shall be stated in a written Memorandum of Understanding. The sponsor shall withdraw services if the station's inability to provide monetary or in-kind support to the project under the Memorandum of Understanding diminishes or jeopardizes the project's financial capabilities to fulfill its obligations.

4. Under no circumstances shall AmeriCorps Seniors volunteers receive fees for service from service recipients, their legal guardians, members of their family, or friends.

D. Labor and anti-labor activity.

The sponsor shall not use grant funds directly or indirectly to finance labor or antilabor organizations or related activities.

E. Fair labor standards.

A sponsor that employs laborers and mechanics for construction, alteration, or repair of facilities shall pay wages at prevailing rates as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended, 40 U.S.C. 276a.

F. Religious activities.

Neither an AmeriCorps Seniors volunteer, nor a member of the project staff funded by AmeriCorps, shall give religious instruction, conduct worship services or engage in any form of proselytization as part of his or her duties.

1. A sponsor or volunteer station may retain its independence and may continue to carry out its mission, including the definition, development, practice, and expression of its religious beliefs, provided that it does not use AmeriCorps funds to support any inherently religious activities, such as worship, religious instruction, or proselytization, as part of the programs or services funded. If an organization conducts such activities,

the activities must be offered separately, in time or location, from the programs or services funded under this part.

G. Nepotism.

Persons selected for project staff positions shall not be related by blood or marriage to other project staff, sponsor staff or officers, or members of the sponsor Board of Directors, unless there is written concurrence from the community group established by the sponsor and upon prior notification and approval by AmeriCorps.

H. Abortion Services or Referrals.

While charging time to the AmeriCorps program, accumulating service or training hours, or otherwise performing activities supported by the AmeriCorps Seniors program or AmeriCorps Seniors, staff and volunteers may not engage in providing abortion services or referrals for receipt of service.

IV. STIPENDS

The recipient may not expend funds approved for payment of stipends for any other purpose without the prior written approval of AmeriCorps' Portfolio Manager.

V. FAILURE TO MAINTAIN VOLUNTEER SERVICE YEARS

Failure of the Recipient to maintain Volunteer Service Year (VSY) program levels in accordance with the approved work plan and budget covered by the Notice of Grant Award may result in a reduction of funding for the succeeding year in accordance with AmeriCorps Seniors program policies.

VI. EXTERNAL EVALUATION AND DATA COLLECTION

The recipient must cooperate with AmeriCorps and its evaluators in all monitoring and evaluation efforts. As part of this effort, the recipient must collect and submit certain project data, as defined in the Progress Report Supplement (PRS), and must provide data as requested or needed to support external evaluations.

VII. LOBBY DISCLOSURE

A. No Federal appropriated funds may be used by the recipient to pay to any person for influencing or attempting to influence an officer or employee of any Federal agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of

Congress in connection with the awarding of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, or modification of any Federal contract, grant, loan, or cooperative agreement.

B. Any recipient who requests or receives a grant from AmeriCorps shall file with AmeriCorps a certification, set forth in 31 U.S.C. Section 1352 ("Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions"), which generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative branches of the Federal Government in connection with a specific grant or cooperative agreement. By signing and submitting an application, the application provides certification that the recipient understands and will comply with this statutory requirement and that the recipient has not made, and will not make, any payment prohibited under section VII.A. above.

C. For AmeriCorps Seniors grant awards in the Foster Grandparent and Senior Companion Programs that exceed $100,000, pursuant to 31 U.S.C. 1352, the recipient is required to file with AmeriCorps a disclosure report, Standard Form LLL, Disclosure of Lobbying Activities, in accordance with its instructions, at the end of any quarter, when the recipient has paid or agreed to pay, using non-appropriated funds (including any profits from any covered Federal action) any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. If applicable, the report must be submitted to the grantee's AmeriCorps Senior Portfolio Manager.

VIII. REPORTING REQUIREMENTS

The recipient is responsible for timely submission of periodic financial and progress reports during the project period and a final financial report at the end of the period.

A. **Progress Reports.** The recipient shall complete and submit a full progress report at the end of the budget period. The report is submitted through the appropriate electronic system no later than 30 days after the end of the budget period. The recipient shall also submit a Progress Report Lite six months after the start of the budget period through the appropriate electronic system.

B. **Financial Reports.** The recipient shall complete and submit financial reports in eGrants to report the status of all funds. The recipient must submit timely financial reports, reporting on a cumulative basis from the start of the grant over the performance period of the grant, in accordance with AmeriCorps guidelines.

Recipients with budget periods starting in April or October submit according to the following schedule:

Due Date	Reporting Period Covered
April 30	October 1 - March 31
October 30	April 1 – September 30

Recipients with budget periods starting in January or July submit according to the following schedule:

Due Date	Reporting Period Covered
July 30	January 1 – June 30
January 30	July 1 – December 31

C. **Final Financial Report.** Recipients completing the final year of their award must submit, in lieu of the last semi-annual financial report, a final financial report in eGrants. This final financial report is due no later than 120 days after the end of the project period. Additionally, grantees must submit a quarterly FFR/Federal Cash Transaction Report to PMS no later than 120 days after the end of the project period.

D. **Reporting at the Dept. of Health and Human Services/Payment Management System (HHS/PMS).** All recipients must submit the Federal Financial Report (FFR) Cash Transactions Report on a quarterly basis to the HHS/PMS per the Electronic Funds Transfer Agreement.

E. **Requests for Extensions.** Each recipient must submit required reports by the given dates. Extensions of reporting deadlines will be granted only when: 1) the report cannot be furnished in a timely manner for reasons, in the determination of AmeriCorps, which are legitimately beyond the control of the recipient, and 2) AmeriCorps receives a written request explaining the need for an extension before the due date of the report.

Extensions of deadlines for reports may only be granted by the AmeriCorps Portfolio Manager, as appropriate.

IX. PROGRAM INCOME

A. **General.** Income, including fees for service earned as a direct result of the grant- funded program activities during the grant period, must be retained by the recipient and used to finance the grant's non- AmeriCorps share.

B. **Excess Program Income.** Program income earned in excess of the amount needed to finance the recipient share must follow the appropriate requirements of 2 CFR § 200.307(e)(1) and be deducted from total claimed costs, or with prior written approval from AmeriCorps, the requirements of 2 CFR § 200.307(e)(2) through a budget amendment have unexpended program income must report it online "o" of the Federal Financial Report (FFR).

C. **Fees for service.** When using assistance under this grant, the recipient may not enter into a contract for or accept fees for service performed by participants when:

1. The service benefits a for-profit entity.

2. The service falls within the other prohibited activities set forth in statute, regulation, or these grant terms and conditions.

X. BUDGET AND PROGRAMMATIC CHANGES

A. **Programmatic Changes.** The recipient must first obtain the prior written approval of the AmeriCorps Portfolio Manager before making any of the following changes (1-3):

1. Changes in the scope, objectives or goals of the project, transfer of the project effort, or project timeline whether or not they involve budgetary changes.

2. Substantial changes in key personnel specified in the application.

3. The disengagement from the project for more than three months, or at least a 25 percent reduction in time devoted to the project by the approved Project Director.

Upon notification to the AmeriCorps Portfolio Manager, recipients may make programmatic changes due to, or in response to, an officially declared state or national disaster without written approval from AmeriCorps. As soon as practicable, recipients making disaster-related programmatic changes must discuss the performance measure adjustments, and other AmeriCorps grant requirements with the AmeriCorps Portfolio Manager. While written approval from AmeriCorps is not required before making disaster-related programmatic changes, AmeriCorps reserves the right to limit or deny disaster-related programmatic changes, including disallowing costs associated with the disaster related activities.

B. **Budgetary Changes.** The recipient must obtain the prior written approval of AmeriCorps' Portfolio Manager before deviating from the approved budget in any of the following ways:

1. Specific Costs Requiring Prior Approval before Incurrence under the uniform administrative requirement, cost principles, and audit requirements for Federal grants at 2 CFR § 200.407. Certain cost items in 2 CFR § 200.407 require prior written approval of the awarding agency for the cost to be allowable such as pre-award costs. Please ensure you consult the regulations prior to incurring costs to ensure allowability.

2. Purchases of Equipment over $5,000 using grant funds, unless specified in the approved application and budget.

3. Unless the AmeriCorps share of the grant is $100,000 or less, changes to cumulative and/or aggregate budget line items that amount to 10 percent or more of the total budget must be approved in writing in advance by AmeriCorps. The total budget includes both the AmeriCorps and recipient shares. Recipients may transfer funds among approved direct cost categories when the cumulative amount of such transfers does not exceed 10 percent of the total budget.

C. **Approval of Programmatic and Budget Changes.** AmeriCorps' Portfolio Managers are the only officials who have the authority to alter or change the terms and conditions or requirements of the grant. Portfolio Managers will execute written amendments and recipients should not assume approvals have been granted unless documentation from AmeriCorps' Office of Grant Administration (OGA) has been received via a Notice of Grant Award. Programmatic changes also require final approval of AmeriCorps' OGA after written recommendation for approval is received from the Portfolio Manager.

XI. NATIONAL SERVICE CRIMINAL HISTORY CHECK TRAINING

All recipients **must** complete and retain a certificate of completion of the AmeriCorps' National Service Criminal History Check (NSCHC) e-course training every year to ensure that recipients conducting criminal history background checks comply with all NSCHC requirements. The AmeriCorps designated e-course provides a thorough overview of the requirements and can be found at: https://americorpsonlinecourses.litmos.com. Each grant recipient must identify at minimum one staff person who has some responsibility for NSCHC compliance to fulfill this requirement on behalf of the grant recipient. The grant recipient must retain the certificate of completion and assign staff to retake the course annually prior to the expiration of the certificate. Grant recipients must save certificates of completion from each year as grant records.

2022 Terms and Conditions for Retired and Senior Volunteer Program (RSVP) Grants

These AmeriCorps (AmeriCorps is the operating name for the Corporation for National and Community Service) **Grant Program Specific Terms and Conditions and the General Terms and Conditions, are binding on the recipient.**

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I. CHANGES FROM THE 2021 RSVP GRANT TERMS AND CONDITIONS

- Section III.H. Added Abortion Services or Referrals to Prohibited Activities.
- Section VI.A. Added a Progress Report Lite.
- Section VI.D. Emphasized that grantees must submit a quarterly Federal Financial Report (FFR)/Federal Cash Transaction Report to the Dept. of Health and Human Services/Payment Management System (HHS/PMS) as part of the final financial reconciliation of the grant.
- Section IX: Updated the links for the required National Service Criminal History Check Training.

II. AWARD PERIOD AND INCREMENTAL FUNDING

For the purpose of this award, a project period is the complete length of time the recipient is proposed to be funded to complete approved activities under the award. A project period may contain one or more budget periods. A budget period is a specific interval of time for which Federal funds are being provided to fund a recipient's approved activities and budget.

Unless otherwise specified, the award covers a three-year project period. In approving a multi-year project period, AmeriCorps generally makes an initial award for the first year of operation. Additional funding is contingent upon satisfactory performance, a recipient's demonstrated capacity to manage an award and comply with award requirements, and the availability of Congressional appropriations. AmeriCorps reserves the right to adjust the amount of an award or elect not to continue funding for subsequent years. The project period and the budget period are noted on the award document.

III. PROHIBITION ON USE OF FUNDS

As specified in 42 U.S.C. § 5043(c) and 45 CFR § 2553.91, while charging time to an RSVP grant, accumulating service or training hours, or otherwise performing activities supported by the RSVP grant or AmeriCorps, staff and volunteers may not engage in the following activities:

A. Political activities.

1. No part of any award shall be used to finance, directly or indirectly, any activity to influence the outcome of any election to public office, or any voter registration activity.

   No project shall be conducted in a manner involving the use of funds, the provision of services, or the employment or assignment of personnel in a matter supporting or resulting in the identification of such project with:

   a. Any partisan or nonpartisan political activity associated with a candidate, or contending faction or group, in an election; or

   b. Any activity to provide voters or prospective voters with transportation to the polls or similar assistance in connection with any such election; or

   c. Any voter registration activity, except that voter registration applications and nonpartisan voter registration information may be made available to the public at the premises of the sponsor. But in making registration applications and nonpartisan voter registration information available, employees of the sponsor shall not express preferences or seek to influence decisions concerning any candidate, political party, election issue, or voting decision.

2. Notwithstanding 42 U.S.C. § 5043(c) and 45 CFR § 2553.91(a)(3), in accordance with AmeriCorps' current appropriations legislation all recipients are prohibited, without exception, from using AmeriCorps funds to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

B. Non-displacement of employed workers. An AmeriCorps Seniors volunteer shall not perform any service or duty or engage in any activity that would otherwise be performed by an employee of the sponsor, or that would supplant the hiring of, or result in the displacement of, employees, or impair existing contracts for services.

C. Compensation for service. An agency or organization to which AmeriCorps Seniors volunteers are assigned, or which operates or supervises any RSVP program shall not request or receive any compensation from AmeriCorps Seniors volunteers or from beneficiaries for services of AmeriCorps Seniors volunteers.

1. The regulations do not prohibit a sponsor from soliciting and accepting voluntary contributions from the community at large to meet its local support obligations under the award or from entering into agreements with parties other than beneficiaries to support additional volunteers beyond those supported by the AmeriCorps award.

2. A volunteer station may contribute to the financial support of the RSVP Program. However, this support shall not be a required precondition for a potential station to obtain RSVP Program services.

3. If a volunteer station agrees to provide funds to support additional RSVP volunteers or pay for other volunteer support costs, the agreement shall be stated in a written Memorandum of Understanding. The sponsor shall withdraw services if the station's inability to provide monetary or in-kind support to the project under the Memorandum of Understanding diminishes or jeopardizes the project's financial capabilities to fulfill its obligations.

4. Under no circumstances shall an RSVP volunteer receive a fee for service from service recipients (i.e., program beneficiaries), their legal guardians, members of their families, or friends.

D. Labor and anti-labor activity. The sponsor shall not use award funds directly or indirectly to finance labor or anti-labor organizations or related activities.

E. Fair labor standards. A sponsor that employs laborers and mechanics for construction, alteration, or repair of facilities shall pay wages at prevailing rates as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended, 40 U.S.C. 276a.

F. Religious activities. Neither an RSVP volunteer nor a member of the project staff funded by AmeriCorps shall give religious instruction, conduct worship services, or engage in any form of proselytization as part of his or her service or duties.

1. A sponsor or volunteer station may retain its independence and may continue to carry out its mission, including the definition, development, practice, and expression of its religious beliefs, provided that it does not use AmeriCorps funds to support any inherently religious activities, such as worship, religious instruction, or proselytization, as part of the programs or services funded. If an organization conducts such activities, the activities must be offered separately, in time or location, from the programs or services funded under this part.

G. Nepotism. Persons selected for project staff positions shall not be related by blood or marriage to other project staff, sponsor staff or officers, or members of the sponsor Board of Directors, unless there is written concurrence from the community group established by the sponsor under Subpart B of this part and upon prior notification and approval by AmeriCorps.

H. Abortion Services or Referrals.
While charging time to the AmeriCorps program, accumulating service or training hours, or otherwise performing activities supported by the AmeriCorps Seniors program or AmeriCorps Seniors, staff and volunteers may not engage in providing abortion services or referrals for receipt of service.

IV. EXTERNAL EVALUATION AND DATA COLLECTION

The recipient must cooperate with AmeriCorps and its evaluators in all monitoring and evaluation efforts. As part of this effort, the recipient must collect and submit certain project data, as defined in the Progress Report Supplement (PRS) and must provide data as requested or needed to support external evaluations.

V. LOBBY DISCLOSURE

A. No Federal appropriated funds may be used by the recipient to pay to any person for influencing or attempting to influence an officer or employee of any Federal agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal grant, the making of any Federal loan, the entering into of any cooperative

agreement, and the extension, continuation, renewal, or modification of any Federal contract, grant, loan, or cooperative agreement.

B. Any recipient who requests or receives a grant from AmeriCorps Seniors shall file with AmeriCorps a certification, set forth in 31 U.S.C. Section 1352 ("Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions"), which generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative branches of the Federal Government in connection with a specific grant or cooperative agreement. By signing and submitting an application, the application provides certification that the recipient understands and will comply with this statutory requirement and that the recipient has not made, and will not make, any payment prohibited under section V.A. above.

C. For RSVP awards exceeding $100,000, pursuant to 31 U.S.C. 1352, the recipient is required to file with AmeriCorps a disclosure report, Standard Form LLL, Disclosure of Lobbying Activities, in accordance with its instructions, at the end of any quarter, when the recipient has paid or agreed to pay, using non-appropriated funds (including any profits from any covered Federal action) any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. If applicable, the report must be submitted to the grantee's AmeriCorps Senior Portfolio Manager.

VI. REPORTING REQUIREMENTS

The recipient is responsible for timely submission of periodic financial and progress reports during the project period and a final financial report at the end of the period.

A. **Progress Reports.** The recipient shall complete and submit a full progress report at the end of the budget period. The report is submitted through the appropriate electronic system no later than 30 days after the end of the budget period. The recipient shall also submit a Progress Report Lite six months after the start of the budget period through the appropriate electronic system.

B. **Financial Reports.** The recipient shall complete and submit financial reports in eGrants to report the status of all funds. The recipient must submit timely financial reports, reporting on a cumulative basis from the start of the award over the performance period of the award, in accordance with AmeriCorps guidelines.

Recipients with budget periods starting in April or October submit according to the following schedule:

Due Date	Reporting Period Covered
April 30	October 1 - March 31
October 30	April 1 – September 30

Recipients with budget periods starting in January or July submit according to the following schedule:

Due Date	Reporting Period Covered
July 30	January 1 – June 30
January 30	July 1 – December 31

C. **Final Financial Report.** Recipients completing the final year of their award must submit, in lieu of the last semi-annual financial report, a final financial report in eGrants. This final financial report is

due no later than 120 days after the end of the project period. Additionally, grantees must submit a quarterly FFR/Federal Cash Transaction Report to PMS no later than 120 days after the end of the project period.

D. **Reporting at the Dept. of Health and Human Services/Payment Management System (HHS/PMS).** All recipients must submit the Federal Financial Report (FFR) Cash Transactions Report on a quarterly basis to the HHS/PMS per the Electronic Funds Transfer Agreement.

E. **Requests for Extensions.** Each recipient must submit required reports by the given dates. Extensions of reporting deadlines will be granted only when: 1) the report cannot be furnished in a timely manner for reasons, in the determination of AmeriCorps, which are legitimately beyond the control of the Recipient, and 2) AmeriCorps receives a written request explaining the need for an extension before the due date of the report.

Extensions of deadlines for reports may only be granted by the AmeriCorps Portfolio Manager, as appropriate.

VII. PROGRAM INCOME

A. **General.** Income, including fees for service earned as a direct result of the award-funded program activities during the award period, must be retained by the recipient and used to finance the award's non-AmeriCorps share.

B. **Excess Program Income.** Program income earned in excess of the amount needed to finance the recipient share must follow the appropriate requirements of 2 CFR Parts 200 and 2205, in particular, 2 CFR 200.307 – Program Income and be deducted from total claimed costs, or with approval from AmeriCorps, through a budget amendment used to enhance the program (additive process). Recipients that have unexpended program income must report it on line "o" of the Federal Financial Report (FFR).

C. **Fees for service.** When using assistance under this award, the recipient may not enter into a contract for or accept fees for service performed by participants when:

1. The service benefits a for-profit entity.

2. The service falls within the other prohibited activities set forth in statute, regulation, or these award terms and conditions.

VIII. BUDGET AND PROGRAMMATIC CHANGES

A. **Programmatic Changes.** The recipient must first obtain the prior written approval of the AmeriCorps Portfolio Manager before making any of the following changes (1-3):

1. Changes in the scope, objectives or goals of the project, transfer of the project effort, or project timeline whether or not they involve budgetary changes.

2. Substantial changes in key personnel specified in the application.

3. The disengagement from the project for more than three months, or a 25 percent reduction in time devoted to the project by the approved Project Director. Upon notification to the AmeriCorps Portfolio Manager, recipients may make programmatic changes due to, or in response to, an officially declared state or national disaster without written approval from AmeriCorps. As soon as practicable, recipients making disaster-related programmatic changes must discuss the performance measure adjustments, and other AmeriCorps award requirements with the AmeriCorps Portfolio Manager. While written approval from AmeriCorps is not required before making disaster-related programmatic changes, AmeriCorps reserves the right to limit or deny disaster-related programmatic changes, including disallowing costs associated with the disaster related activities.

B. Budgetary Changes. The recipient must obtain the prior written approval of AmeriCorps' Portfolio Manager before deviating from the approved budget in any of the following ways:

1. Specific Costs Requiring Prior Approval before Incurrence under the uniform administrative requirement, cost principles, and audit requirements for Federal awards at 2 CFR § 200.407. Certain cost items in 2 CFR § 200.407 require prior written approval of the awarding agency for the cost to be allowable such as pre-award costs. Please ensure you consult the regulations prior to incurring costs to ensure allowability.

2. Purchases of Equipment over $5,000 using award funds, unless specified in the approved application and budget.

3. Unless the AmeriCorps share of the award is $100,000 or less, changes to cumulative and/or aggregate budget line items that amount to 10 percent or more of the total budget must be approved in writing in advance by AmeriCorps. The total budget includes both the AmeriCorps and recipient shares. Recipients may transfer funds among approved direct cost categories when the cumulative amount of such transfers does not exceed 10 percent of the total budget.

C. Approval of Programmatic and Budget Changes. AmeriCorps' Portfolio Managers are the only officials who have the authority to alter or change the terms and conditions or requirements of the award. Portfolio Managers will execute written amendments and recipients should not assume approvals have been granted unless documentation from AmeriCorps' Office of Grant Administration (OGA) has been received via a notice of grant award. Programmatic changes also require final approval of AmeriCorps' OGA after written recommendation for approval is received from the Portfolio Manager.

IX. NATIONAL SERVICE CRIMINAL HISTORY CHECK TRAINING

All recipients **must** complete and retain a certificate of completion of the AmeriCorps' National Service Criminal History Check (NSCHC) e-course training every year to ensure that recipients conducting criminal history background checks comply with all NSCHC requirements. The AmeriCorps designated e-course provides a thorough overview of the requirements and can be found at: https://americorpsonlinecourses.litmos.com.

Each grant recipient must identify at minimum one staff person who has some responsibility for NSCHC compliance to fulfill this requirement on behalf of the grant recipient. The grant recipient must retain the certificate of completion and assign staff to retake the course annually prior to the expiration of the certificate. Grant recipients must save certificates of completion from each year as grant records.

IN WITNESS WHEREOF, the parties have executed this Agreement on the date set forth below.

CITY OF SANTA FE:

_____

ALAN WEBBER, MAYOR

DATE: _____

ATTEST:

_____

KRISTINE BUSTOS-MIHELCIC, CITY CLERK

CITY ATTORNEY'S OFFICE:

Marcos Martinez

Marcos Martinez (Nov 7, 2022 15:23 MST)

_____

MARCOS MARTINEZ, SENIOR ASSISTANT CITY ATTORNEY

APPROVED FOR FINANCES:

_____

EMILY OSTER, FINANCE DIRECTOR

Revenue 2410116/490510 Expense 2410116/Object-Various AH

AH

_____

ORG/OBJECT

City of Santa Fe, New Mexico
Memorandum

DATE: November 14, 2022

TO: Governing Body
Finance Committee
Quality of Life Committee

VIA: John Blair, City Manager
Emily Oster, Finance Department Director
Joann Lovato, Interim Chief Procurement Officer
Kyra Ochoa, Community Health and Safety Director
Paul Joye, Chief of Police
Matthew Champlin, Deputy Chief of Police
Anthony Tapia, Captain

FROM: Jose Gonzales, Lieutenant

ITEM AND ISSUE:
Request for a General Fund budget increase and approval of NM Department of Transportation for the funding of projects: End Driving While Impaired (ENDWI) Project # 03-AL-64-090; Buckle Up (BKLUP)/Click it or Ticket (CIOT) Project # 03-OP-RF-090, Selective Traffic Enforcement Program (STEP)/Summer Enforcement Period Project # 03-PT-RF-090 in the Total Project Amount of $83,749. (Lieutenant Jose Gonzales, jcgonzales@santafenm.gov)

BACKGROUND AND SUMMARY:

The attached project award to the City of Santa Fe Police Department is from the New Mexico Department of Transportation and does not require matching funds from the City of Santa Fe. The project funds reimburse the City of Santa Fe Police Department for eligible expenses required to conduct projects aimed at reducing traffic-related injuries and deaths. End Driving While Impaired (ENDWI) Project # 03-AL-64-090 for $44,198 will allow officers to conduct sobriety checkpoints and DWI directed enforcement patrols in high crash locations identified in data compiled by local, state, or federal government agencies and included in the City's Operational Plan. Buckle Up (BKLUP)/Click it or Ticket (CIOT) Project # 03-OP-RF-090 for $9,220 is to conduct occupant protection directed enforcement patrols in high crash locations. Selective Traffic Enforcement Program (STEP)/Summer Enforcement Period Project # 03-PT-RF-090 for $30,331 is to conduct directed enforcement patrols in high crash locations identified in data compiled by local, state, or federal government agencies and the City's Operational Plan.

The agreement becomes effective upon signature of both parties and ends September 30, 2023. This request is to increase the General Fund Budget – Police Overtime 10000065.501400 in the amount of $83,749.

ACTION REQUESTED:
The Santa Fe Police Department respectfully requests your review and approval.

Log # *(Finance use only)*:	
Journal # *(Finance use only)*:	

City of Santa Fe, New Mexico
BUDGET AMENDMENT RESOLUTION (BAR)

DEPARTMENT / DIVISION NAME	DATE
Police/Administration	11/14/2022

ITEM DESCRIPTION	ORG	OBJECT	PROJECT	INCREASE	DECREASE
EXPENDITURES				*(enter as positive #)*	*(enter as negative #)*
Police Overtime	1000065	501400	POL2310001	83,749	
REVENUES				*(enter as negative #)*	*(enter as positive #)*
NM Dept of Transportation - State Grants	10000001	490150	POL2310001	(83,749)	

JUSTIFICATION: *(use additional page if needed)*
--Attach supporting documentation/memo

To record NM Department of Transportation traffic projects; ENDWI $44,198; BKLUP/CIOT $9,220; and STEP $30,331. For a total of $83,749.

(Complete section below if BAR results in a net change to ANY Fund)

Fund(s) Affected	Fund Balance Increase/(Decrease)
100	0
TOTAL:	0

AnnaMarie Bowen	11/14/22	*(Use this form for Finance Committee/ City Council agenda items ONLY)*		Andy Hopkins Andy Hopkins (Nov 18, 2022 09:15 MST)	Nov 18, 2022
Prepared By *(print name)*	Date	**CITY COUNCIL APPROVAL**		Budget Officer	Date
Division Director Signature *(optional)*	Date	*City Council Approval Date*		Finance Director *(≤ $5,000)*	Date
Paul Joye Paul Joye (Nov 16, 2022 10:15 MST)	Nov 16, 2022	*Agenda Item #:*			
Department Director Signature	Date			City Manager *(≤ $60,000)*	Date

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New Mexico DEPARTMENT OF TRANSPORTATION
MOBILITY FOR EVERYONE

MEMORANDUM

Date: October 5, 2022

To: Ricky Serna, Cabinet Secretary

Through: Jeff Barela, Director, Traffic Safety Division

From: Kimberly Wildharber, Staff Manager

Subject: Letter of Justification for Grant Agreement between the New Mexico Department of Transportation Traffic Safety Division and City of Santa Fe.

Michelle Lujan Grisham
Governor

Ricky Serna
Cabinet Secretary

Commissioners

Jennifer Sandoval
Commissioner, Vice-Chairman
District 1

Bruce Ellis
Commissioner
District 2

Hilma E. Chynoweth
Commissioner
District 3

Walter G. Adams
Commissioner, Chairman
District 4

Thomas C. Taylor
Commissioner
District 5

Charles Lundstrom
Commissioner, Secretary
District 6

1. TSD Program Manager John Vargas, Phone # 505-231-6784, will oversee the project(s).

2. The Consolidated Agreement provides funding to Santa Fe Police Department to conduct the following project(s) and activities as shown below.
   - ENDWI – $44,198.00 (annually) (Fed 164)
     The ENDWI program funds overtime enforcement for DWI checkpoint and DWI directed patrol program. Funds are used to maintain the program, as funding allows, and to expand the program in areas of the State with high rates of DWI.
   - BKLUP -- $9,220.00 (annually) (State Road Fund)
     The BKLUP program funds overtime for law enforcement agencies to conduct safety belt and child restraint/ booster seat use activities to increase in occupant protection use in New Mexico.
   - STEP – $30,331.00 (annually) (State Road Fund)
     Provides funding for sustained enforcement program to target specific traffic problems such as speed, DWI, road rage, distracted and reckless driving, fatigue/ drowsy driving, occupant protection, and crashes involving pedestrians, primarily through the use of Safety Corridors. Participating agencies include local law enforcement.

3. The agreement will be effective from date of last signature to 9/30/2024.

4. A deliverables table is listed in Exhibit A-C.

5. The agreement is Exempt from the procurement as it is with another government agency, (per NMSA 1978 Section 13-1-98, et seq.)

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New Mexico DEPARTMENT OF TRANSPORTATION
MOBILITY FOR EVERYONE

October 5, 2022

Lieutenant Jose Gonzales
Santa Fe Police Department
2515 Camino Entrada
Santa Fe, NM 87505

RE: Project Agreement

Dear Coordinator:

Enclosed is the project agreement for the federal 2023 and 2024 fiscal years. This letter contains information required to meet Federal Funding Accountability and Transparency Act (FFATA) and 2 CFR Part 200 requirements for FY 2023 only. An updated letter will be provided for FFY 2024 funding and superblitz dates at a later date. Please provide a copy of this letter to the person responsible for meeting those requirements at your City, County, Town or Tribal agency. The following table contains the information necessary to meet these requirements.

Project Number	Funding Source	CFDA #	FAIN	Award Date	Amount
03-AL-64-090	BIL 164 Transfer Funds	20.608	69A3752230000164ONMA	5/16/2022	$44,198.00
03-OP-RF-090	State Road Fund				$9,220.00
03-PT-RF-090	State Road Fund				$30,331.00

2 CFR Subpart F 200.500-521
(a) Audit required. A non-Federal entity that expends $750,000 or more during the non-Federal entity's fiscal year in Federal awards must have a single or program-specific audit conducted for that year in accordance with the provisions of this part.

(b) Single audit. A non-Federal entity that expends $750,000 or more during the non-Federal entity's fiscal year in Federal awards must have a single audit conducted in accordance with §200.514 Scope of audit except when it elects to have a program-specific audit conducted in accordance with paragraph (c) of this section.

(c) *Program-specific audit election.* When an auditee expends Federal awards under only one Federal program (excluding R&D) and the Federal program's statutes, regulations, or the terms and conditions of the Federal award do not require a financial statement audit of the auditee, the auditee may elect to have a program-specific audit conducted in accordance with §200.507 Program-specific audits. A program-specific audit may not be elected for R&D unless all of the Federal awards expended were received from the same Federal agency, or the same Federal agency and the same pass-through entity, and that Federal agency, or pass-through entity in the case of a subrecipient, approves in advance a program-specific audit.

Michelle Lujan Grisham
Governor

Ricky Serna
Cabinet Secretary

Commissioners

Jennifer Sandoval
Commissioner, Vice-Chairman
District 1

Bruce Ellis
Commissioner
District 2

Hilma E. Chynoweth
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New Mexico DEPARTMENT OF TRANSPORTATION
MOBILITY FOR EVERYONE

(d) Exemption when Federal awards expended are less than $750,000. A non-Federal entity that expends less than $750,000 during the non-Federal entity's fiscal year in Federal awards is exempt from Federal audit requirements for that year, except as noted in §200.503 Relation to other audit requirements, but records must be available for review or audit by appropriate officials of the Federal agency, pass-through entity, and Government Accountability Office (GAO).

If expenditures are less than $750,000 during your agency's fiscal year 2022, please submit a statement to the Traffic Safety Division at the address listed on this letterhead. The Statement should read, "We did not meet the $750,000 expenditure threshold and therefore we are not required to have a single audit performed for FY {22}."

Your agency must submit copies of any audits and review reports which they have had prepared to the Department for informational purposes if requested regardless of whether the criteria for audit or review are met.

Operational Plan
Your agency is required to develop an operational plan to include a jurisdiction-specific performance goal, problem statement, problem identification and basic crash data upon which the project is based. Performance goals should be specific, measurable, action-oriented, realistic, and time-bound.

Performance Indicators
The Department has implemented performance indicators on Department funded law enforcement projects. The performance indicators are as follows:
ENDWI Medium Agency (Populations 50,000 - 99,000) - 1 DWI in 32 Hours
BKLUP 1 seat belt or child restraint citation for every 2 hours of enforcement worked.
STEP 2 citations or warnings for every hour of enforcement worked.

At no time does the New Mexico Department of Transportation require an individual officer to issue a specific number of citations during an enforcement period.

We look forward to working with you to prevent injuries and fatalities. Thank you for your cooperation.

Sincerely,

DocuSigned by:
Barela
E281EAE93FAE441...

Jeff Barela, Director
Traffic Safety Division

Enclosure

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Office of General Counsel Contract Brief Form

Date: October 5, 2022 **From: John Vargas** **Location: Traffic Safety Division**

Phone: 505-231-6784 **Agency: NMDOT**

Contractor: Santa Fe Police Department

Project No.: 03-AL-64-090, 03-OP-RF-090, 03-PT-RF-090

NEW CONTRACT
__ Copy of RFP, if applicable
__ Copy of approved sole source justification
__ Copy of approved small purchase justification
__ Copy of Contract Brief signed by Contract Administration

AMENDMENT TO EXISTING CONTRACT
__ Scope of Work
__ Additional Compensation
__ Time extension
Note: For amendments please attach a copy of the original agreement, any previous amendments, and a copy of the RFP. (If applicable)

X EXEMPT FROM PROCUREMENT PROCESS (university: other educational institutions; other state agency, bureau; local public bodies).

The Office of General Counsel's policy for turnaround time is ten (10) working days. Please indicate below if there are extenuating circumstances, which require immediate review of this agreement.

Attorney Review Comments

The attached agreement is being returned for revisions or corrections. Please call at (505) 469-6411 if you have any questions.
____Please make corrections on pages _
____I have signed the agreement with the understanding that you will make the corrections indicated on the agreement submitted for review or discussed with you.
____Please make corrections on pages and return the marked copy to the receptionist for further review and approval.

Other Comments

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CONTRACT NUMBER:
UNIQUE ENTITY IDENTIFIER: QLN2YKMMJ8X6
SUPPLIER: 0000054360

GRANT AGREEMENT

This Grant Agreement (**Agreement**) is between the New Mexico Department of Transportation (**Department**) and City of Santa Fe (**Grantee**), collectively referred to as the "parties." This Agreement is effective as of the date of the last party to sign it on the signature page below. The Department and the Grantee agree as follows:

1. **Award.** The Department hereby awards the Grantee funding for the following projects:

   a. End Driving While Impaired (**ENDWI**), Project No. 03-AL-64-090, $44,198.00; 04-AL-64-090, $44,198.00

   b. Buckle Up (**BKLUP**)/Click It or Ticket (**CIOT**), Project No. 03-OP-RF-090, $9,220.00; 04-OP-RF-090, $9,220.00.

   c. Selective Traffic Enforcement Program (**STEP**), Project No. 03-PT-RF-090, $30,331.00; 04-PT-RF-090, $30,331.00,

   d. Total Funding awarded per this Agreement $167,498.00

2. **Scope of Work.** The Grantee shall perform the professional services stated in the following exhibits: **Exhibit A** - ENDWI; **Exhibit B** - BKLUP/CIOT; **Exhibit C** - STEP.

3. **Payment.** To be reimbursed for eligible expenses, the Grantee must submit timely and properly prepared reimbursement requests as provided in the Department's Electronic Grant Management System or the Traffic Safety Division Financial Management Manual 2019, as directed by the Department. The Grantee acknowledges that the Department will not pay for any expenses incurred prior to both Parties signing the Agreement, after termination of the Agreement, or in excess of the amount of the award noted in Section 1. The Grantee must submit its final reimbursement request no later than forty-five (45) calendar days after termination of this Agreement, unless otherwise approved by the Department.

4. **Records and Audit.** The Grantee shall strictly account for all receipts and disbursements related to this Agreement. The Grantee shall record costs incurred, services rendered, and payment received. The Grantee shall maintain these financial records during the term of this Agreement and for three (3) years from the date of submission of the final reimbursement request. On request, the Grantee shall provide the financial records to the Department and the state auditor, and shall allow the Department and the state auditor to inspect or audit these financial records during business hours at the Grantee's principal office during the term of this Agreement and for three (3) years from the date of submission of the final reimbursement request. If the financial records provided by the Grantee are insufficient to support an audit by customary accounting practices, the Grantee shall reimburse the Department for any expense incurred related to the insufficient documentation within thirty (30) calendar days of written notice from the Department. If an audit or inspection reveals that funds were used for expenses not directly related to the project or were used inappropriately, or that payments were excessive or otherwise

erroneous, the Grantee shall reimburse the Department for those funds or payments within thirty (30) calendar days of written notice.

5. **Officials Not to Benefit.** The parties intend that no member of the New Mexico legislature or the United States Congress, or any public official, public employee or tribal council member, in that person's individual capacity, will benefit from this Agreement.

6. **Termination.** The Department may terminate this Agreement for any reason, by giving the Grantee thirty (30) calendar days written notice. On receipt of a "Notice of Cancellation," the Grantee shall suspend work unless otherwise directed by the Department in writing. The Grantee may only terminate this Agreement based on the Department's uncured, material breach of the Agreement and by giving the Department thirty (30) calendar days' written notice. The Parties acknowledge that termination will not nullify obligations incurred prior to termination, including any obligations intended to survive termination of the Agreement, including but not limited to Section 4 and Section 11.

7. **Appropriations.** The Grantee acknowledges that:

   a. this Agreement is contingent upon sufficient appropriations and authorizations being made by the Congress of the United States or the New Mexico state legislature;
   b. if sufficient appropriations and authorizations are not made, this Agreement will terminate upon written notice by the Department to the Grantee; and
   c. the Department will not expend any funds until approved for expenditure, and the Department's determination as to whether approval has been granted will be final.

8. **Compliance with Law.** The Grantee, its employees, agents and contractors, shall comply with the following:

   a. Title VI and Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, the Americans with Disabilities Act of 1990, the ADA Amendments Act of 2008, the Environmental Justice Act of 1994, the Civil Rights Restoration Act of 1987, and 49 C.F.R. Section 21;
   b. all applicable federal and state laws, rules, regulations, and executive orders pertaining to equal employment opportunity, including the Human Rights Act, NMSA 1978, Sections 28-1-1 through 28-1-15, and in accordance with such, the Grantee states that no person, on the grounds of race, religion, national origin, sex, sexual orientation, gender identity, spousal affiliation, serious medical condition, age, disability, or other protected class will be excluded from employment with or participation in, denied the benefits of, or otherwise subjected to, discrimination in any activity performed under this Agreement; if the Grantee is found to be in violation of any of these requirements, the Grantee shall take prompt and appropriate steps to correct such violation, subject to Section 6 above;
   c. state laws applicable to workers compensation benefits for the Grantee's employees, including the Workers' Compensation Act, NMSA 1978, Sections 52-1-1 through 52-1-70, and related rules;
   d. 2 C.F.R. 200, Subpart F - Audit Requirements, Sections 200.500 - 200.521; and
   e. those sections in Appendix A to Part 1300 labeled "applies to subrecipients as well as states."

9. **Notices.** For a notice under this Agreement to be valid, it must be in writing; be delivered by hand, registered or certified mail postage prepaid, fax or email; and be addressed as follows:

to the Department at:	to the Grantee at:
New Mexico Dept. of Transportation	Santa Fe Police Department
Attn: Traffic Safety Division	Attn: Lieutenant Jose Gonzales
P.O. Box 1149	2515 Camino Entrada
Santa Fe, NM 87504	Santa Fe, NM 87505

10. **Severability.** The terms of this Agreement are lawful; performance of all duties and obligations shall confirm with and do not contravene any state, local, or federal statute, regulation, rule, or ordinance. The parties intend that if any provision of this Agreement is held to be unenforceable, the rest of the Agreement will remain in effect as written.

11. **Liability.** Neither party shall be responsible for liability incurred as a result of the other party's acts or omissions in connection with this Agreement. Any liability incurred in connection with the Agreement is subject to the immunities and limitations of the New Mexico Tort Claims Act, NMSA 1978, Sections 41-4-1, *et seq.*, as amended, and any other applicable law. This section is intended only to define the liabilities between the parties and it is not intended to modify in any way, the Parties' liabilities as governed by law.

12. **Project Responsibility.** The Grantee acknowledges that it bears sole responsibility for performing the services referred to in Exhibits A, B and C, Scope of Work, Training, Reimbursement and Reporting.

13. **Term.** This Agreement takes effect as of the date the last party to sign it on the signature page below. The grantee may not start work until directed to by the Department. The Agreement terminates at 12:00 a.m. on September 30, 2023, unless earlier terminated as provided in Section 6 or Section 7.

14. **Applicable Law.** The laws of the state of New Mexico, without giving effect to its choice of law provisions, govern all adversarial proceedings arising out of this Agreement.

15. **Jurisdiction and Venue.** The Grantee acknowledges the jurisdiction of the courts of the state of New Mexico for any adversarial proceeding arising out of this Agreement, and that venue for any such proceeding will be in the First Judicial District Court for the county of Santa Fe, New Mexico.

16. **Amendment.** No amendment of this Agreement will be effective unless it is in writing and signed by the parties.

17. **No Third-party Beneficiary.** This Agreement does not confer any rights or remedies on anyone other than the Department and the Grantee.

18. **Scope of Agreement and Merger.** This Agreement incorporates all the agreements, covenants, and understanding between the parties concerning the subject matter of this Agreement. No prior agreements or understandings, verbal or otherwise, of the parties or their agents will be valid unless included in this Agreement.

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19. **Disadvantaged Business Enterprise.** The following provision applies to a USDOT-assisted federally funded agreement only. The recipient shall not discriminate on the basis of race, color, national origin, sex, or other protected class in the award and performance of any USDOT-assisted contract or in the administration of its DBE program or the requirements of 49 CFR Part 26. The recipient shall take all necessary and reasonable steps under 49 CFR Part 26 to ensure nondiscrimination in the award and administration of USDOT-assisted contracts. The recipient's DBE program, as required by 49 CFR Part 26 and as approved by USDOT, is incorporated by reference in this Agreement. Implementation of this program is a legal obligation and failure to carry out its terms shall be treated as a violation of this Agreement. Upon notification to the recipient of its failure to carry out its approved program, the USDOT may impose sanctions as provided for under Part 26 and may, in appropriate cases, refer the matter for enforcement under 18 U.S.C. 1001 and/or the Program Fraud Civil Remedies Act of 1986 (31 U.S.C. 3801 *et seq.*).

The remainder of this page is intentionally left blank.

Each party is signing this Agreement on the date stated opposite that party's signature. This Agreement is effective as of the date of the last party to sign it on the signature page below.

NEW MEXICO DEPARTMENT OF TRANSPORTATION

By: _____ Date: _____
Cabinet Secretary or Designee

CITY OF SANTA FE

By: _____ Date: _____

Title: Alan Webber, Mayor

Approved as to form and legal sufficiency.

By: DocuSigned by: _____ Date: 10/13/2022
Assistant General Counsel
Department of Transportation

Approved as to form and legal sufficiency.

By: Marcos Martinez _____ Date: Nov 3, 2022
Marcos Martinez (Nov 3, 2022 11:58 MDT)
Counsel for City of Santa Fe

Attest:

By:_____ Date:_____
Kristine Bustos Mihelcic, City Clerk

Approved for Finances:
By:_____ Date:_____
Emily Oster, Finance Director

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Exhibit A: Scope of Work, Training, Reimbursement and Reporting

END DRIVING WHILE IMPAIRED (ENDWI) Project Number: 03-AL-64-090; 04-AL-64-090

1. **Scope of Work.** The Grantee shall conduct sobriety checkpoints (SCs) and DWI directed enforcement patrols (DDEPs) as negotiated between the Department and the Grantee, in high crash locations identified in data compiled by local, state or federal government agencies and included the Grantee's Operational Plan. The Department encourages the Grantee to accompany SCs and DDEPs with public information, media and educational activities. SCs must be scheduled to be staffed by at least 5 officers as required by *City of Las Cruces v. Bentancourt, 1987-NMAC-039.* and must last a minimum of 4 hours. Number of officers should meet the amount required by *Bentancourt* but not exceed the number detailed in the Grantees Operational Plan. If for any reason, the SC is not staffed with the minimum number of officers or was not conducted for the minimum number of hours, the Grantee must submit a justification with the invoice for these services. The Department may choose to deny the invoice for SCs based on the justification. DDEPs must deploy officers in high crash locations consistent with the enforcement plan. If for any reason, the DDEPs were conducted in areas not consistent with the enforcement plan, the Grantee must submit a justification with the invoice for these services. The Department may choose to deny the invoice for DDEPs based on the justification. The Grantee is encourage to schedule SCs and DDEPs throughout the grant period with a focus on participating during the Superblitz Period, 3 Mini Superblitz Periods, and National DWI Mobilizations as identified below.

2. **Definitions.** For purposes of this exhibit, the following definitions apply:

   "Agency Coordinator" means the person assigned by the Grantee to assume direct responsibility for administering all phases of the Agreement.

   "Directed Enforcement Patrols" means activities that enforce traffic laws in areas consistent with the agency's operational plan.

   "Operational Plan" means a plan based on the most current crash data that identifies the problem to be addressed, goals to be achieved, and the performance measures to be employed. The Grantee may update its operational plan as needed to align with current trends.

   "Winter Superblitz Period" means November 18, 2022 to January 1, 2023.

   "St. Patrick's Day Mini Superblitz Period" means March 11 to March 19, 2023.

   "Cinco de Mayo May Mini Superblitz Period" means May 1 to May 7, 2023.

   "Fourth of July Mini Superblitz Period" means July 1 to July 8, 2023.

   "National DWI Mobilization Period" means August 18 to September 4, 2023.

3. **Training and Qualifications.** The Agency Coordinator must attend the Department's Law Enforcement Coordinators symposium and other Department training as required. The Grantee should notify the Department of any changes in the Agency Coordinator as soon as possible. The Grantee's participating officers must have law enforcement certifications in all areas necessary to

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conduct the services noted in Section 1 of this exhibit. The Grantee shall keep documentation of training and provide the Department with a list of certified officers on request.

4. **Reimbursement.** The Department will pay the Grantee for the actual cost paid to personnel that worked the SCs and DDEPs. Claims for payment must specify officers' actual hourly rate of overtime pay based on the Grantee's overtime policy; the Department will not pay any amount in excess of that rate or for any amount that is not above and beyond the officers normal duties. The Grantee should submit claims at minimum quarterly no later than January 30th, April 30th and July 30th during this Agreement period. The final claim shall be submitted no later than October 31, 2023 for FFY 2023 funds and October 31, 2024 for FFY 2024 funds. If the final claim is submitted after October 31 of the applicable fiscal year noted above, the claim must be accompanied by a justification letter. The Department may choose to deny the claim based on the justification. The claim must be on a form approved by the Department. The Department will pay the Grantee for the following:

   a. pay, including overtime, for officers conducting traffic safety DWI enforcement in areas consistent with the enforcement plan;
   b. pay, including overtime, for officers attendance at administrative license revocation hearings and court hearings directly related to DWI arrests made while participating in the ENDWI program;
   c. overtime costs for officers or authorized personnel to support activities directly related to the SCs and/or DDEPs conducted during the claim month. Authorized personnel may include dispatcher, transport or others as authorized by checkpoint supervisor or command staff. The Grantee can only claim up to 10 percent of the total monthly claim amount; and
   d. in state travel and related expenses for officers to attend DWI related training approved by the Department in advance and shall be reimbursed in accordance with the Regulation Governing the New Mexico Per Diem and Mileage Act, 2.42.2 NMAC.

5. **Reporting.** *The Grantee must submit activity reports by the 20th of each month using the activity report form provided unless otherwise directed by the Department.* Activity reports must include the type of activity and types of citations issued. The Grantee must report all citations to the Motor Vehicle Division of the New Mexico Taxation and Revenue Department and to the appropriate court in accordance with New Mexico state statute. The Grantee must submit timely crash reports to the Department in accordance with NMSA 1978, Section 66-7-207. If the Grantee is not submitting crash reports in accordance with NMSA 1978, Section 66-7-207, the Department may hold reimbursement claims until this provision is met.

6. **Funding.** The Department expects the funding source to be BIL 164 Transfer Funds and the Catalog of Federal Domestic Assistance (CFDA) number to be 20.608. However, both funding source and CFDA number are subject to change at the Department's discretion. The Grantee may transfer funds between budget categories only with prior written approval from the Department. The project's itemized budget is as follows:

FY23	03-AL-64-090
Personal Services	$44,198.00
Contractual Services	$0.00
Commodities	$0.00
Indirect	$0.00
Other	$0.00
TOTAL	$44,198.00

FY24	04-AL-64-90
Personal Services	$44,198.00
Contractual Services	$0.00
Commodities	$0.00
Indirect	$0.00
Other	$0.00
TOTAL	$44,198.00

7. **Goals.** The Department's performance goals for the state are as follows: Five-year alcohol-impaired fatalities rose by 13.4 percent between 2016 and 2020, with continued, but with a smaller increase projected between 2020 and 2023. The State has determined to set the five-year average projection of 131.2 as the 2023 target. The State's ENDWI and participation in the National Drive Sober or Get Pulled Over enforcement and media will continue to focus on areas of the State that have higher incidents of alcohol-involved crashes, fatalities and injuries, and among high-risk groups such as young male drivers, motorcyclists and pedestrians.

8. **Equipment.** The Grantee may only purchase equipment under this Agreement with prior written approval of the Department.

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Exhibit B: Scope of Work, Training, Reimbursement and Reporting

BUCKLE UP (BKLUP) and CLICK IT OR TICKET (CIOT) Project Number: 03-OP-RF-090; 04-OP-RF-090

1. **Scope of Work.** The Grantee shall conduct occupant protection directed enforcement patrols (ODEPs) in high crash locations identified in data compiled by local, state or federal government agencies and the Grantee's Operational Plan. The Department encourages the Grantee to accompany the ODEPs with public information, media and educational activities. ODEPs must deploy officers in high crash locations consistent with the enforcement plan for occupant protection issues. If for any reason, the ODEPs were conducted in areas not consistent with the enforcement plan, the Grantee must submit a justification with the invoice for these services. The Department may choose to deny the invoice for ODEPs based on the justification. The Grantee is encouraged to schedule ODEPs throughout the grant period with a focus on participating during the Superblitz Period, 3 Mini Superblitz Periods, National DWI Mobilizations and the National Click It or Ticket Mobilizations identified below.

2. **Definitions.** For purposes of this exhibit, the following definitions apply:

   "Agency Coordinator" means the person assigned by the Grantee to assume direct responsibility for administering all phases of the Agreement.

   "Directed Enforcement Patrols" means activities that enforce traffic laws in areas consistent with the agency's operational plan.

   "Operational Plan" means a plan based on the most current crash data that identifies the problem to be addressed, goals to be achieved, and the performance measures to be employed. The Grantee may update its operational plan as needed to align with current trends.

   "Winter Superblitz Period" means November 18, 2022 to January 1, 2023.

   "St. Patrick's Day Mini Superblitz Period" means March 11 to March 19, 2023.

   "Cinco de Mayo May Mini Superblitz Period" means May 1 to May 7, 2023.

   "National Occupant Protection Mobilization Click It or Ticket period" means May 22 to June 4, 2023.

   "Fourth of July Mini Superblitz Period" means July 1 to July 8, 2023.

   "National DWI Mobilization Period" means August 18 to September 4, 2023.

3. **Training and Qualifications.** The Agency Coordinator must attend the Department's Law Enforcement Coordinators symposium and other Department training as required. The Grantee should notify the Department of any changes in the Agency Coordinator as soon as possible. The Grantee's participating officers must have law enforcement certifications in all areas necessary to conduct the services noted in Section 1 of this exhibit. The Grantee shall keep documentation of training and provide the Department with a list of certified officers on request.

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4. **Reimbursement.** The Department will pay the Grantee for the actual cost paid to personnel that worked the ODEPs. Claims for payment must specify officers' actual hourly rate of overtime pay based on the Grantee's overtime policy; the Department will not pay any amount in excess of that rate or for any amount that is not above and beyond the officers normal duties. The Grantee should submit claims at minimum quarterly no later than January 30th, April 30th and July 30th during this Agreement period. The final claim shall be submitted no later than October 31, 2023 for FFY 2023 funds and October 31, 2024 for FFY 2024 funds. If the final claim is submitted after October 31 of the applicable fiscal year noted above, the claim must be accompanied by a justification letter. The Department may choose to deny the claim based on the justification. The claim must be on a form approved by the Department. The Department will pay the Grantee for the following:

   a. pay, including overtime, for officers conducting traffic safety occupant protection focused enforcement in areas consistent with the enforcement plan;
   b. attendance at, and excess per diem for, operation safe kids training and the four-day NHTSA standardized child passenger safety training; and
   c. assistance at child safety seat clinics or car seat fitting stations.

5. **Reporting.** *The Grantee must submit activity reports by the 20th of each month using the activity report form provided unless otherwise directed by the Department.* Activity reports must include the type of activity and types of citations issued. The Grantee must report all citations to the Motor Vehicle Division of the New Mexico Taxation and Revenue Department and to the appropriate court in accordance with New Mexico state statute. The Grantee must submit timely crash reports to the Department in accordance with NMSA 1978, Section 66-7-207. If the Grantee is not submitting crash reports in accordance with NMSA 1978, Section 66-7-207, the Department may hold reimbursement claims until this provision is met.

1. **Funding.** The Department expects the funding source to be state road fund. However, the funding source is subject to change at the Department's discretion. The Grantee may transfer funds between budget categories only with prior written approval from the Department. The project's itemized budget is as follows:

FY 23	03-OP-RF-090
Personal Services	$9,220.00
Contractual Services	$0.00
Commodities	$0.00
Indirect	$0.00
Other	$0.00
TOTAL	$9,220.00

FY 24	04-OP-RF-090
Personal Services	$9,220.00
Contractual Services	$0.00
Commodities	$0.00
Indirect	$0.00
Other	$0.00
TOTAL	$9,220.00

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7. **Goals.** The Department's performance goals for the state are to:

   a. Five-year unrestrained occupant fatalities rose by 11.6 percent between 2016 and 2020, and projected five-year data indicate a further 18.5 percent rise in 2023. The State has set the five-year average projection of 138.6 as the 2023 target. The State will continue to support its BKLUP enforcement and awareness campaign and its participation in the National CIOT in an effort to reduce these fatalities. The State requested and participated in an Occupant Protection Assessment in May of 2022 to obtain guidance from NHTSA to improve our OP programs and reduce unrestrained crashes and fatalities.

   b. The State anticipates being able to increase its seat belt use to at least 90 percent in 2023 and although projections indicate 89.8 percent use in 2023, the State has determined to set the 2023 target at 90.1 percent observed use. Until 2021, New Mexico's observed seat belt use percentage had remained above 90 percent since 2011.

8. **Equipment.** The Grantee may only purchase equipment under this Agreement with prior written approval of the Department.

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Exhibit C: Scope of Work, Training, Reimbursement and Reporting

SELECTIVE TRAFFIC ENFORCEMENT PROGRAM (STEP) and
SUMMER ENFORCEMENT PERIOD Project Number: 03-PT-RF-090; 04-PT-RF-090

1. **Scope of Work.** The Grantee shall conduct directed enforcement patrols (DEPs) in high crash locations identified in data compiled by local, state or federal government agencies and the Grantee's Operational Plan. The Department encourages the Grantee to accompany the DEPs with public information, media and educational activities. DEPs must deploy officers in high crash locations consistent with the Operational Plan. If for any reason, the DEPs were conducted in areas not consistent with the Operational Plan, the Grantee must submit a justification with the invoice for these services. The Department may choose to deny the invoice for DEPs based on the justification. *The Grantee is encouraged to schedule DEPS through the grant period with a focus on participating during the Summer enforcement period which runs June 21, 2023 through September 23, 2023.*

2. **Definitions.** For purposes of this exhibit, the following definitions apply:

   "Agency Coordinator" means the person assigned by the Grantee to assume direct responsibility for administering all phases of the Agreement.

   "Directed Enforcement Patrols" means activities that enforce traffic laws in areas consistent with the agency's operational plan.

   "Operational Plan" means a plan based on the most current crash data that identifies the problem to be addressed, goals to be achieved, and the performance measures to be employed. The Grantee may update its operational plan as needed to align with current trends.

3. **Training and Qualifications.** The Agency Coordinator must attend the Department's Law Enforcement Coordinators symposium and other Department training as required. The Grantee should notify the Department of any changes in the Agency Coordinator as soon as possible. The Grantee's participating officers must have law enforcement certifications in all areas necessary to conduct the services noted in Section 1 of this exhibit. The Grantee shall keep documentation of training and provide the Department with a list of certified officers on request.

4. **Reimbursement.** The Department will pay the Grantee for the actual cost paid to personnel that worked the DEPs. Claims for payment must specify officers' actual hourly rate of overtime pay based on the Grantee's overtime policy; the Department will not pay any amount in excess of that rate or for any amount that was not above and beyond the officer's normal duties. The Grantee should submit claims at minimum quarterly no later than January 30th, April 30th and July 30th during this Agreement period. The final claim shall be submitted no later than October 31, 2023 for FFY 2023 funds and October 31, 2024 for FFY 2024 funds. If the final claim is submitted after October 31 of the applicable fiscal year noted above, the claim must be accompanied by a justification letter. The Department may choose to deny the claim based on the justification. The claim must be on a form approved by the Department. The Department will pay the Grantee for the following:

a. Pay, including overtime pay, for officers conducting the traffic safety enforcement described in paragraph 1 of this **Exhibit C**; and

b. training for officers as approved by the Department. Pay for travel and traffic safety related training

5. **Reporting.** *The Grantee must submit activity reports by the 20th of each month using the activity report form provided unless otherwise directed by the Department.* Activity reports must include the type of activity and types of citations issued. The Grantee must report all citations to the Motor Vehicle Division of the New Mexico Taxation and Revenue Department and to the appropriate court in accordance with New Mexico state statute. The Grantee must submit timely crash reports to the Department in accordance with NMSA 1978, Section 66-7-207. If the Grantee is not submitting crash reports in accordance with NMSA 1978, Section 66-7-207, the Department may hold reimbursement claims until this provision is met.

6. **Funding – STEP.** The Department expects the funding source to be State Road Fund. However, the funding source is subject to change at the Department's discretion. The Grantee may transfer funds between budget categories only with prior written approval from the Department. The project's itemized budget is as follows:

FY 23	03-PT-RF-090
Personal Services	$30,331.00
Contractual Services	$0.00
Commodities	$0.00
Indirect	$0.00
Other	$0.00
TOTAL	$30,331.00

FY 24	03-PT-RF-090
Personal Services	$30,331.00
Contractual Services	$0.00
Commodities	$0.00
Indirect	$0.00
Other	$0.00
TOTAL	$30,331.00

7. **Goals.** The Department's performance goals for the state are as follows:

a. Five-year speeding-related fatalities rose by 12.7 percent between 2016 and 2020, and continue to show an upward trend into 2023. During the peak COVID-19 period (2020-2021), speeding-related fatalities increased by 15.6 percent, and were 38.6 percent of all crash fatalities in 2021. Given the projected continued rise in these fatalities, the State has determined to set the five-year average projection of 174.2 as the 2023 target.

b. Five-year alcohol-impaired fatalities rose by 13.4 percent between 2016 and 2020, with continued, but with a smaller increase projected between 2020 and 2023. The State has

determined to set the five-year average projection of 131.2 as the 2023 target. The State's ENDWI and participation in the National Drive Sober or Get Pulled Over enforcement and media will continue to focus on areas of the State that have higher incidents of alcohol-involved crashes, fatalities and injuries, and among high-risk groups such as young male drivers, motorcyclists and pedestrians.

c. Five-year unrestrained occupant fatalities rose by 11.6 percent between 2016 and 2020, and projected five-year data indicate a further 18.5 percent rise in 2023. The State has set the five-year average projection of 138.6 as the 2023 target. The State will continue to support its BKLUP enforcement and awareness campaign and its participation in the National CIOT in an effort to reduce these fatalities. The State requested and participated in an Occupant Protection Assessment in May of 2022 to obtain guidance from NHTSA to improve our OP programs and reduce unrestrained crashes and fatalities.

d. The State anticipates being able to increase its seat belt use to at least 90 percent in 2023 and although projections indicate 89.8 percent use in 2023, the State has determined to set the 2023 target at 90.1 percent observed use. Until 2021, New Mexico's observed seat belt use percentage had remained above 90 percent since 2011.

e. Five-year average fatalities rose by 13 percent between 2016 and 2020. 2021 preliminary data indicate a 20 percent increase in fatalities in 2021, with 2022 and 2023 projected increases at similar levels. The State has determined to set the five-year average projection of 446.6 as the 2023 target.

f. The methodology used to project the 5-year moving average number of suspected serious injuries for 2023 resulted in a target of 953.5, a 10 percent decrease from the previous year's target, and a larger decrease than in the years since 2016. Therefore, the State has determined a target of 995.4 to be more in-line with the anticipated decrease in the 5-year moving average of suspected serious injuries for 2023.

g. Annual motorcyclist fatalities rose from 47 in 2016 to 53 in 2017 and to 55 in 2019 before falling to 46 in 2020. Preliminary data indicate a large rise to 55 in 2021 and projected data show fatalities staying at this level into 2023. As gas prices are anticipated to remain high for some time, and motorcycle travel expected to increase, as evidenced by recent increases in motorcycle sales, the State has determined to set the annual projected target of 54.

h. Five-year average under-21 drivers in fatal crashes have risen steadily from 42 in 2016 to 52 in 2020. Preliminary 2021 and projected data indicate continued increases into 2023; therefore the State has determined to set the five-year average projection of 60 as the 2023 target.

i. Annual pedestrian fatalities remained in the 74 to 83 range from 2016 to 2020; however 2021 preliminary data indicate a high of 103 fatalities (a 30% increase from 2020), and projected data for 2023 show the number of fatalities remaining at 103. Five-year average data indicate a 26 percent increase in these fatalities, and the State has determined to set the five-year average projection of 93 as the 2023 target.

j. Bicyclist fatalities rose from 4 in 2016 to a high of 11 in 2018, then down to 8 in 2020. Preliminary data indicate a reduction to 6 fatalities in 2021, but projections indicate a rise to higher levels close to those in 2018. Given these fluctuations, the State has determined to set the five-year average projection of 9 as the 2023 target.

8. **Equipment.** The Grantee may only purchase equipment under this Agreement with prior written approval of the Department.

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Appendix A to Part 1300 – Certifications and Assurances for Fiscal Year 2023 Highway Safety Grants (23 U.S.C. Chapter 4; Sec. 1906, Pub. L. 109-59, As Amended By Sec. 4011, Pub. L. 114-94)

[*Each fiscal year, the Governor's Representative for Highway Safety must sign these Certifications and Assurances affirming that the State complies with all requirements, including applicable Federal statutes and regulations, that are in effect during the grant period. Requirements that also apply to subrecipients are noted under the applicable caption.*]

State: New Mexico Fiscal Year: 2023

By submitting an application for Federal grant funds under 23 U.S.C. Chapter 4 or Section 1906, the State Highway Safety Office acknowledges and agrees to the following conditions and requirements. In my capacity as the Governor's Representative for Highway Safety, I hereby provide the following Certifications and Assurances:

GENERAL REQUIREMENTS

The State will comply with applicable statutes and regulations, including but not limited to:

- 23 U.S.C. Chapter 4 – Highway Safety Act of 1966, as amended
- Sec. 1906, Pub. L. 109-59, as amended by Sec. 4011, Pub. L. 114-94
- 23 CFR part 1300 – Uniform Procedures for State Highway Safety Grant Programs
- 2 CFR part 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards
- 2 CFR part 1201 – Department of Transportation, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards

INTERGOVERNMENTAL REVIEW OF FEDERAL PROGRAMS

The State has submitted appropriate documentation for review to the single point of contact designated by the Governor to review Federal programs, as required by Executive Order 12372 (Intergovernmental Review of Federal Programs).

FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA)

The State will comply with FFATA guidance, OMB Guidance on FFATA Subward and Executive Compensation Reporting, August 27, 2010, (https://www.fsrs.gov/documents/OMB_Guidance_on_FFATA_Subaward_and_Executive_Compensation_Reporting_08272010.pdf) by reporting to FSRS.gov for each sub-grant awarded:

- Name of the entity receiving the award;
- Amount of the award;
- Information on the award including transaction type, funding agency, the North American Industry Classification System code or Catalog of Federal Domestic Assistance number (where applicable), program source;

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- Location of the entity receiving the award and the primary location of performance under the award, including the city, State, congressional district, and country; and an award title descriptive of the purpose of each funding action;
- A Unique Entity identifier;
- The names and total compensation of the five most highly compensated officers of the entity if:
  (i) the entity in the preceding fiscal year received—
    (I) 80 percent or more of its annual gross revenues in Federal awards;
    (II) $25,000,000 or more in annual gross revenues from Federal awards; and
  (ii) the public does not have access to information about the compensation of the senior executives of the entity through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986;
- Other relevant information specified by OMB guidance.

NONDISCRIMINATION
(applies to subrecipients as well as States)

The State highway safety agency will comply with all Federal statutes and implementing regulations relating to nondiscrimination ("Federal Nondiscrimination Authorities"). These include but are not limited to:

- **Title VI of the Civil Rights Act of 1964** (42 U.S.C. 2000d *et seq.*, 78 stat. 252), (prohibits discrimination on the basis of race, color, national origin) and 49 CFR part 21;
- **The Uniform Relocation Assistance and Real Property Acquisition Policies** Act of 1970, (42 U.S.C. 4601), (prohibits unfair treatment of persons displaced or whose property has been acquired because of Federal or Federal-aid programs and projects);
- **Federal-Aid Highway Act of 1973**, (23 U.S.C. 324 *et seq.),* **and Title IX of the Education Amendments of 1972**, as amended (20 U.S.C. 1681-1683 and 1685-1686) (prohibit discrimination on the basis of sex);
- **Section 504 of the Rehabilitation Act of 1973**, (29 U.S.C. 794 *et seq.),* as amended, (prohibits discrimination on the basis of disability) and 49 CFR part 27;
- **The Age Discrimination Act of 1975**, as amended, (42 U.S.C. 6101 *et seq.),* (prohibits discrimination on the basis of age);
- **The Civil Rights Restoration Act of 1987**, (Pub. L. 100-209), (broadens scope, coverage and applicability of Title VI of the Civil Rights Act of 1964, The Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1973, by expanding the definition of the terms "programs or activities" to include all of the programs or activities of the Federal aid recipients, subrecipients and contractors, whether such programs or activities are Federally-funded or not);
- **Titles II and III of the Americans with Disabilities Act** (42 U.S.C. 12131-12189) (prohibits discrimination on the basis of disability in the operation of public entities, public and private transportation systems, places of public accommodation, and certain testing) and 49 CFR parts 37 and 38;

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- **Executive Order 12898, Federal Actions to Address Environmental Justice in Minority Populations and Low-Income Populations** (prevents discrimination against minority populations by discouraging programs, policies, and activities with disproportionately high and adverse human health or environmental effects on minority and low-income populations); and
- **Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency** (guards against Title VI national origin discrimination/discrimination because of limited English proficiency (LEP) by ensuring that funding recipients take reasonable steps to ensure that LEP persons have meaningful access to programs (70 FR 74087-74100).

The State highway safety agency—

- Will take all measures necessary to ensure that no person in the United States shall, on the grounds of race, color, national origin, disability, sex, age, limited English proficiency, or membership in any other class protected by Federal Nondiscrimination Authorities, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any of its programs or activities, so long as any portion of the program is Federally-assisted;

- Will administer the program in a manner that reasonably ensures that any of its subrecipients, contractors, subcontractors, and consultants receiving Federal financial assistance under this program will comply with all requirements of the Non-Discrimination Authorities identified in this Assurance;

- Agrees to comply (and require its subrecipients, contractors, subcontractors, and consultants to comply) with all applicable provisions of law or regulation governing US DOT's or NHTSA's access to records, accounts, documents, information, facilities, and staff, and to cooperate and comply with any program or compliance reviews, and/or complaint investigations conducted by US DOT or NHTSA under any Federal Nondiscrimination Authority;

- Acknowledges that the United States has a right to seek judicial enforcement with regard to any matter arising under these Non-Discrimination Authorities and this Assurance;

- Agrees to insert in all contracts and funding agreements with other State or private entities the following clause:

  "During the performance of this contract/funding agreement, the contractor/funding recipient agrees—

  a. To comply with all Federal nondiscrimination laws and regulations, as may be amended from time to time;

  b. Not to participate directly or indirectly in the discrimination prohibited by any Federal non-discrimination law or regulation, as set forth in appendix B of 49 CFR part 21 and herein;

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c. To permit access to its books, records, accounts, other sources of information, and its facilities as required by the State highway safety office, US DOT or NHTSA;

d. That, in event a contractor/funding recipient fails to comply with any nondiscrimination provisions in this contract/funding agreement, the State highway safety agency will have the right to impose such contract/agreement sanctions as it or NHTSA determine are appropriate, including but not limited to withholding payments to the contractor/funding recipient under the contract/agreement until the contractor/funding recipient complies; and/or cancelling, terminating, or suspending a contract or funding agreement, in whole or in part; and

e. To insert this clause, including paragraphs (a) through (e), in every subcontract and subagreement and in every solicitation for a subcontract or sub-agreement, that receives Federal funds under this program.

THE DRUG-FREE WORKPLACE ACT OF 1988 (41 U.S.C. 8103)

The State will provide a drug-free workplace by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing a drug-free awareness program to inform employees about:
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs;
   4. The penalties that may be imposed upon employees for drug violations occurring in the workplace;
   5. Making it a requirement that each employee engaged in the performance of the grant be given a copy of the statement required by paragraph (a);

c. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will –
   1. Abide by the terms of the statement;
   2. Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;

d. Notifying the agency within ten days after receiving notice under subparagraph (c)(2) from an employee or otherwise receiving actual notice of such conviction;

e. Taking one of the following actions, within 30 days of receiving notice under subparagraph (c)(2), with respect to any employee who is so convicted –

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1. Taking appropriate personnel action against such an employee, up to and including termination;
2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

f. Making a good faith effort to continue to maintain a drug-free workplace through implementation of all of the paragraphs above.

POLITICAL ACTIVITY (HATCH ACT)
(applies to subrecipients as well as States)

The State will comply with provisions of the Hatch Act (5 U.S.C. 1501-1508), which limits the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

CERTIFICATION REGARDING FEDERAL LOBBYING
(applies to subrecipients as well as States)

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement;

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions;

3. The undersigned shall require that the language of this certification be included in the award documents for all sub-award at all tiers (including subcontracts, subgrants, and contracts under grant, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who

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fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

RESTRICTION ON STATE LOBBYING
(applies to subrecipients as well as States)

None of the funds under this program will be used for any activity specifically designed to urge or influence a State or local legislator to favor or oppose the adoption of any specific legislative proposal pending before any State or local legislative body. Such activities include both direct and indirect (e.g., "grassroots") lobbying activities, with one exception. This does not preclude a State official whose salary is supported with NHTSA funds from engaging in direct communications with State or local legislative officials, in accordance with customary State practice, even if such communications urge legislative officials to favor or oppose the adoption of a specific pending legislative proposal.

CERTIFICATION REGARDING DEBARMENT AND SUSPENSION
(applies to subrecipients as well as States)

Instructions for Primary Tier Participant Certification (States)

1. By signing and submitting this proposal, the prospective primary tier participant is providing the certification set out below and agrees to comply with the requirements of 2 CFR parts 180 and 1200.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. The prospective primary tier participant shall submit an explanation of why it cannot provide the certification set out below. The certification or explanation will be considered in connection with the department or agency's determination whether to enter into this transaction. However, failure of the prospective primary tier participant to furnish a certification or an explanation shall disqualify such person from participation in thistransaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when the department or agency determined to enter into this transaction. If it is later determined that the prospective primary tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency may terminate this transaction for cause or default or may pursue suspension or debarment.

4. The prospective primary tier participant shall provide immediate written notice to the department or agency to which this proposal is submitted if at any time the prospective primary tier participant learns its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms *covered transaction, civil judgment, debarment, suspension, ineligible, participant, person, principal, and voluntarily excluded*, as used in this clause, are defined in 2 CFR parts

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180 and 1200. You may contact the department or agency to which this proposal is being submitted for assistance in obtaining a copy of those regulations.

6. The prospective primary tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency entering into this transaction.

7. The prospective primary tier participant further agrees by submitting this proposal that it will include the clause titled "Instructions for Lower Tier Participant Certification" including the "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion—Lower Tier Covered Transaction," provided by the department or agency entering into this covered transaction, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions and will require lower tier participants to comply with 2 CFR parts 180 and 1200.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant is responsible for ensuring that its principals are not suspended, debarred, or otherwise ineligible to participate in covered transactions. To verify the eligibility of its principals, as well as the eligibility of any prospective lower tier participants, each participant may, but is not required to, check the System for Award Management Exclusions website (https://www.sam.gov/).

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, the department or agency may terminate the transaction for cause or default.

Certification Regarding Debarment, Suspension, and Other Responsibility Matters-Primary Tier Covered Transactions

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(1) The prospective primary tier participant certifies to the best of its knowledge and belief, that it and its principals:

(a) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in covered transactions by any Federal department or agency;

(b) Have not within a three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or Local) with commission of any of the offenses enumerated in paragraph (1)(b) of this certification; and

(d) Have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

(2) Where the prospective primary tier participant is unable to certify to any of the Statements in this certification, such prospective participant shall attach an explanation to this proposal.

Instructions for Lower Tier Participant Certification

1. By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below and agrees to comply with the requirements of 2 CFR parts 180 and 1200.

2. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal government, the department or agency with which this transaction originated may pursue available remedies, including suspension or debarment.

3. The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

4. The terms *covered transaction, civil judgment, debarment, suspension, ineligible, participant, person, principal, and voluntarily excluded*, as used in this clause, are defined in 2 CFR parts 180 and 1200. You may contact the person to whom this proposal is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this

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covered transaction, unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this proposal that it will include the clause titled "Instructions for Lower Tier Participant Certification" including the "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions and will require lower tier participants to comply with 2 CFR parts 180 and 1200.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant is responsible for ensuring that its principals are not suspended, debarred, or otherwise ineligible to participate in covered transactions. To verify the eligibility of its principals, as well as the eligibility of any prospective lower tier participants, each participant may, but is not required to, check the System for Award Management Exclusions website (https://www.sam.gov).

8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, the department or agency with which this transaction originated may pursue available remedies, including suspension or debarment.

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions:

1. The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in covered transactions by any Federal department or agency.

2. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

BUY AMERICA ACT
(applies to subrecipients as well as States)

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The State and each subrecipient will comply with the Buy America requirement (23 U.S.C. 313) when purchasing items using Federal funds. Buy America requires a State, or subrecipient, to purchase with Federal funds only steel, iron and manufactured products produced in the United States, unless the Secretary of Transportation determines that such domestically produced items would be inconsistent with the public interest, that such materials are not reasonably available and of a satisfactory quality, or that inclusion of domestic materials will increase the cost of the overall project contract by more than 25 percent. In order to use Federal funds to purchase foreign produced items, the State must submit a waiver request that provides an adequate basis and justification for approval by the Secretary of Transportation.

PROHIBITION ON USING GRANT FUNDS TO CHECK FOR HELMET USAGE
(applies to subrecipients as well as States)

The State and each subrecipient will not use 23 U.S.C. Chapter 4 grant funds for programs to check helmet usage or to create checkpoints that specifically target motorcyclists.

POLICY ON SEAT BELT USE

In accordance with Executive Order 13043, Increasing Seat Belt Use in the United States, dated April 16, 1997, the Grantee is encouraged to adopt and enforce on-the-job seat belt use policies and programs for its employees when operating company-owned, rented, or personally-owned vehicles. The National Highway Traffic Safety Administration (NHTSA) is responsible for providing leadership and guidance in support of this Presidential initiative. For information and resources on traffic safety programs and policies for employers, please contact the Network of Employers for Traffic Safety (NETS), a public-private partnership dedicated to improving the traffic safety practices of employers and employees. You can download information on seat belt programs, costs of motor vehicle crashes to employers, and other traffic safety initiatives at www.trafficsafety.org. The NHTSA website (www.nhtsa.gov) also provides information on statistics, campaigns, and program evaluations and references.

POLICY ON BANNING TEXT MESSAGING WHILE DRIVING

In accordance with Executive Order 13513, Federal Leadership On Reducing Text Messaging While Driving, and DOT Order 3902.10, Text Messaging While Driving, States are encouraged to adopt and enforce workplace safety policies to decrease crashes caused by distracted driving, including policies to ban text messaging while driving company-owned or rented vehicles, Government-owned, leased or rented vehicles, or privately-owned vehicles when on official Government business or when performing any work on or behalf of the Government. States are also encouraged to conduct workplace safety initiatives in a manner commensurate with the size of the business, such as establishment of new rules and programs or re-evaluation of existing programs to prohibit text messaging while driving, and education, awareness, and other outreach to employees about the safety risks associated with texting while driving.

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SECTION 402 REQUIREMENTS

1. To the best of my personal knowledge, the information submitted in the Highway Safety Plan in support of the State's application for a grant under 23 U.S.C. 402 is accurate and complete.

2. The Governor is the responsible official for the administration of the State highway safety program, by appointing a Governor's Representative for Highway Safety who shall be responsible for a State highway safety agency that has adequate powers and is suitably equipped and organized (as evidenced by appropriate oversight procedures governing such areas as procurement, financial administration, and the use, management, and disposition of equipment) to carry out the program. (23 U.S.C. 402(b)(1)(A))

3. The political subdivisions of this State are authorized, as part of the State highway safety program, to carry out within their jurisdictions local highway safety programs which have been approved by the Governor and are in accordance with the uniform guidelines promulgated by the Secretary of Transportation. (23 U.S.C. 402(b)(1)(B))

4. At least 40 percent of all Federal funds apportioned to this State under 23 U.S.C. 402 for this fiscal year will be expended by or for the benefit of political subdivisions of the State in carrying out local highway safety programs (23 U.S.C. 402(b)(1)(C)) or 95 percent by and for the benefit of Indian tribes (23 U.S.C. 402(h)(2)), unless this requirement is waived in writing. (This provision is not applicable to the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.)

5. The State's highway safety program provides adequate and reasonable access for the safe and convenient movement of physically handicapped persons, including those in wheelchairs, across curbs constructed or replaced on or after July 1, 1976, at all pedestrian crosswalks. (23 U.S.C. 402(b)(1)(D))

6. The State will provide for an evidenced-based traffic safety enforcement program to prevent traffic violations, crashes, and crash fatalities and injuries in areas most at risk for such incidents. (23 U.S.C. 402(b)(1)(E))

7. The State will implement activities in support of national highway safety goals to reduce motor vehicle related fatalities that also reflect the primary data-related crash factors within the State, as identified by the State highway safety planning process, including:
    - Participation in the National high-visibility law enforcement mobilizations as identified annually in the NHTSA Communications Calendar, including not less than 3 mobilization campaigns in each fiscal year to –
        - Reduce alcohol-impaired or drug-impaired operation of motor vehicles; and
        - Increase use of seat belts by occupants of motor vehicles;
    - Sustained enforcement of statutes addressing impaired driving, occupant protection, and driving in excess of posted speed limits;

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- An annual Statewide seat belt use survey in accordance with 23 CFR part 1340 for the measurement of State seat belt use rates, except for the Secretary of Interior on behalf of Indian tribes;
- Development of Statewide data systems to provide timely and effective data analysis to support allocation of highway safety resources;
- Coordination of Highway Safety Plan, data collection, and information systems with the State strategic highway safety plan, as defined in 23 U.S.C. 148(a).
(23 U.S.C. 402(b)(1)(F))

8. The State will actively encourage all relevant law enforcement agencies in the State to follow the guidelines established for vehicular pursuits issued by the International Association of Chiefs of Police that are currently in effect. (23 U.S.C. 402(j))

9. The State will not expend Section 402 funds to carry out a program to purchase, operate, or maintain an automated traffic enforcement system. (23 U.S.C. 402(c)(4))

I understand that my statements in support of the State's application for Federal grant funds are statements upon which the Federal Government will rely in determining qualification for grant funds, and that knowing misstatements may be subject to civil or criminal penalties under 18 U.S.C. 1001. I sign these Certifications and Assurances based on personal knowledge, and after appropriate inquiry.

DocuSigned by:
Justin Reese
6/28/2022

Signature Governor's Representative for Highway Safety — Date

Justin Reese, Acting Cabinet Secretary

Printed name of Governor's Representative for Highway Safety

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New Mexico Traffic Safety Division Project Information Sheet

Contract Number:			
Government Unit:	Santa Fe, City of		
Contract term:	(– 09/30/2024)		
Supplier Number:	0000054360	Address ID:	

Grantee Contact Info

Project Director and Title:	Lieutenant Jose Gonzales		
Phone:	505-955-5231	E-mail:	jcgonzales@santafenm.gov
Agency Name:	Santa Fe Police Department		
Address:	2515 Camino Entrada		
City, State ZIP:	Santa Fe, NM 87505		

TSD Contact Info

Program Manager:	John Vargas	Phone:	505-231-6784
TSD Finance:	Avalon Gabaldon	Phone:	505-660-8103

Budget Breakdown

Funding	Project Number	Amount	Fund	Department Code	PO Number
ENDWI	03-AL-64-090	$44,198.00	10010	5000000000	
BKLUP	03-OP-RF-090	$9,220.00	20100	5100000000	
STEP	03-PT-RF-090	$30,331.00	20100	5100000000	
	Total	**$83,749.00**			

PO Entered by TSD Finance:		Date:	
PO Approved by Contracts:		Date:	

Comments: A new Project Info sheet will be provided in FFY 2024

CITY OF SANTA FE

PROFESSIONAL SERVICES AGREEMENT

THIS AGREEMENT is made and entered into by and between the City of Santa Fe (the "City") and Life Insurance North America (Cigna Group Insurance) (the "Contractor"). The date of this Agreement shall be the date when it is executed by the City and the Contractor, whichever occurs last.

1. SCOPE OF SERVICES

The Contractor shall provide the following services for the City:

A. All services required to provide Basic Group Life and Accidental Death and Dismemberment (AD&D) insurance for 1400 eligible City of Santa Fe employees and their spouses, domestic partners, and dependent child(ren) of the employee and Supplemental Life Insurance and Accidental Death and Dismemberment insurance to employee, employee's spouse, domestic partners, and dependent child(ren) of the employee.

B. Provide a basic life and AD&D and supplemental life insurance policy with the following specifications:

Quotes:

1) Contractor shall provide quotes based on the City's current policy. See attachment.

2) Contractor shall also provide quotes on a policy such as a $200,000 supplemental life guaranteed option with no evidence of insurability and 50% guaranteed option for the spouses and for domestic partners.

3) Contractor shall provide quotes to include rates for "unismoker".

4) Contractor shall provide quotes for an option of up to 5 times annual salary with maximum benefit of $500,000 for the employee with a 50% option for the spouse and for domestic partners.

5) Contractor shall provide a policy that is portable for the individual that terminates from employment.

6) The 2007 Legislative Act Senate Bill 186 states that undercover agents should be insured for $250,000 on basic life insurance. Quote rate, coverage and three (3) year rate guarantee.

7) Contractor shall provide quotes to provide a one time open enrollment for all current employees subject to guarantee issue.

C. No Loss/No Gain Provision. The insurer shall provide coverage on a discontinuance and replacement basis (sometime referred to as a "no loss/no gain" basis) for eligible employees participating in the current plans on the effective date and to unconditionally provide continuous coverage to all participants enrolled on the program effective date. No active employees, disabled employees or covered dependents shall lose coverage as a result of a change in contractor.

D. Waiver of Actively at Work Clause. Contractor shall unconditionally agree to provide continuous coverage to all present participants. Employees not actively at work due to disablement on the program effective date will be covered. Waiver of Premium for Basic & Supplemental Life should reflect "waived after continuous total disability from any occupation if disabled prior to age 60."

E. Disabled/Leave of Absence Employees. Any disabled employees (or enrolled dependents) or other leave-of-absence employees who are inadvertently not disclosed in these specification or who later are identified as eligible for benefits

with the Contractor will become the liability of the Contractor following termination of the existing contract.

F. Medical Evidence. No statement of health or medical evidence will be imposed on the initial group of covered participants.

G. Pre-Existing Conditions Exclusion. There will be no restrictions or benefit limitations for pre-existing conditions applied to any employees or their dependents covered under the plan(s).

H. Compliance. Contractor certifies that it will comply with the Department of Labor's extension of 2003 final claims procedure regulations including:

1) The notice requirements for improper and incomplete claims;

2) The appropriate time frames for adjudicating urgent, pre-service and post-service claims;

3) The appropriate timeframes for notice of appeal decision.

I. Communication.

1) The City of Santa Fe must be given prior notification of all communication materials sent to City employees.

2) Contractor must be able to accept electronic file, record, and transaction formats utilized by the City. The capability to electronically upload and download data to and from the Contractor's application processing systems without the need to re-key or reformat data is essential.

3) Rate Guarantees. Contractors should provide rate guarantees for three (3) years.

2. STANDARD OF PERFORMANCE; LICENSES

A. The Contractor represents that it possesses the experience and knowledge necessary to perform the services described under this Agreement.

B. The Contractor agrees to obtain and maintain throughout the term of this Agreement, all applicable professional and business licenses required by law, for itself, its employees, agents, representatives and subcontractors.

3. COMPENSATION

A. The City shall pay to the Contractor in full payment for services rendered, a sum not to exceed Three hundred sixteen thousand dollars ($316,000.00),inclusive of applicable gross receipts taxes.

B. The Contractor shall be responsible for payment of gross receipts taxes levied by the State of New Mexico on the sums paid under this Agreement.

C. Contractor will bill the City per monthly enrollment.

4. APPROPRIATIONS

The terms of this Agreement are contingent upon sufficient appropriations and authorization being made by the City for the performance of this Agreement. If sufficient appropriations and authorization are not made by the City, this Agreement shall terminate upon written notice being given by the City to the Contractor. The City's decision as to whether sufficient appropriations are available shall be accepted by the Contractor and shall be final.

5. TERM AND EFFECTIVE DATE

This Agreement shall be effective when signed by the City and the

Contractor, whichever occurs last, and shall terminate on June 30, 2015, unless sooner pursuant to Article 6 below.

6. TERMINATION

A. This Agreement may be terminated by the City upon 30 days written notice to the Contractor. Upon termination, the City shall pay the Contractor one (1) month's enrollment from the date of termination.

7. STATUS OF CONTRACTOR; RESPONSIBILITY FOR PAYMENT OF EMPLOYEES AND SUBCONTRACTORS

A. The Contractor and its agents and employees are independent contractors performing professional services for the City and are not employees of the City. The Contractor, and its agents and employees, shall not accrue leave, retirement, insurance, bonding, use of City vehicles, or any other benefits afforded to employees of the City as a result of this Agreement.

B. Contractor shall be solely responsible for payment of wages, salaries and benefits to any and all employees or subcontractors retained by Contractor in the performance of the services under this Agreement.

C. The Contractor shall comply with City of Santa Fe Minimum Wage, Article 28-1-SFCC 1987, as well as any subsequent changes to such article throughout the term of this Agreement.

8. CONFIDENTIALITY

Any confidential information provided to or developed by the Contractor in the performance of this Agreement shall be kept confidential and shall not be made available to any individual or organization by the Contractor without the prior written approval of the City.

9. CONFLICT OF INTEREST

The Contractor warrants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of services required under this Agreement. Contractor further agrees that in the performance of this Agreement no persons having any such interests shall be employed.

10. ASSIGNMENT; SUBCONTRACTING

The Contractor shall not assign or transfer any rights, privileges, obligations or other interest under this Agreement, including any claims for money due, without the prior written consent of the City. The Contractor shall not subcontract any portion of the services to be performed under this Agreement without the prior written approval of the City.

11. RELEASE

The Contractor, upon acceptance of final payment of the amount due under this Agreement, releases the City, its officers and employees, from all liabilities, claims and obligations whatsoever arising from or under this Agreement. The Contractor agrees not to purport to bind the City to any obligation not assumed herein by the City unless the Contractor has express written authority to do so, and then only within the strict limits of that authority.

12. INSURANCE

A. The Contractor, at its own cost and expense, shall carry and maintain in full force and effect during the term of this Agreement, comprehensive general liability insurance covering bodily injury and property damage liability, in a form and with an insurance company acceptable to the City, with limits of coverage in the

maximum amount which the City could be held liable under the New Mexico Tort Claims Act for each person injured and for each accident resulting in damage to property. Such insurance shall provide that the City is named as an additional insured and that the City is notified no less than 30 days in advance of cancellation for any reason. The Contractor shall furnish the City with a copy of a Certificate of Insurance as a condition prior to performing services under this Agreement.

B. Contractor shall also obtain and maintain Workers' Compensation insurance, required by law, to provide coverage for Contractor's employees throughout the term of this Agreement. Contractor shall provide the City with evidence of its compliance with such requirement.

C. Contractor shall maintain professional liability insurance throughout the term of this Agreement providing a minimum coverage in the amount required under the New Mexico Tort Claims Act. The Contractor shall furnish the City with proof of insurance of Contractor's compliance with the provisions of this section as a condition prior to performing services under this Agreement.

13. INDEMNIFICATION

The Contractor shall indemnify, hold harmless and defend the City from all losses, damages, claims or judgments, including payments of all attorneys' fees and costs on account of any suit, judgment, execution, claim, action or demand whatsoever arising from Contractor's performance under this Agreement as well as the performance of Contractor's employees, agents, representatives and subcontractors.

14. NEW MEXICO TORT CLAIMS ACT

Any liability incurred by the City of Santa Fe in connection with this Agreement is subject to the immunities and limitations of the New Mexico Tort Claims Act,

Section 41-4-1, et. seq. NMSA 1978, as amended. The City and its "public employees" as defined in the New Mexico Tort Claims Act, do not waive sovereign immunity, do not waive any defense and do not waive any limitation of liability pursuant to law. No provision in this Agreement modifies or waives any provision of the New Mexico Tort Claims Act.

15. THIRD PARTY BENEFICIARIES

By entering into this Agreement, the parties do not intend to create any right, title or interest in or for the benefit of any person other than the City and the Contractor. No person shall claim any right, title or interest under this Agreement or seek to enforce this Agreement as a third party beneficiary of this Agreement.

16. RECORDS AND AUDIT

The Contractor shall maintain, throughout the term of this Agreement and for a period of three years thereafter, detailed records that indicate the date, time and nature of services rendered. These records shall be subject to inspection by the City, the Department of Finance and Administration, and the State Auditor. The City shall have the right to audit the billing both before and after payment. Payment under this Agreement shall not foreclose the right of the City to recover excessive or illegal payments.

17. APPLICABLE LAW; CHOICE OF LAW; VENUE

Contractor shall abide by all applicable federal and state laws and regulations, and all ordinances, rules and regulations of the City of Santa Fe. In any action, suit or legal dispute arising from this Agreement, the Contractor agrees that the laws of the State of New Mexico shall govern. The parties agree that any action or suit arising from this Agreement shall be commenced in a federal or state court of competent jurisdiction in New Mexico. Any action or suit commenced in the courts of the State of New Mexico shall be brought in the First Judicial District Court.

18. AMENDMENT

This Agreement shall not be altered, changed or modified except by an amendment in writing executed by the parties hereto.

19. SCOPE OF AGREEMENT

This Agreement incorporates all the agreements, covenants, and understandings between the parties hereto concerning the services to be performed hereunder, and all such agreements, covenants and understandings have been merged into this Agreement. This Agreement expresses the entire Agreement and understanding between the parties with respect to said services. No prior agreement or understanding, verbal or otherwise, of the parties or their agents shall be valid or enforceable unless embodied in this Agreement.

20. NON-DISCRIMINATION

During the term of this Agreement, Contractor shall not discriminate against any employee or applicant for an employment position to be used in the performance of services by Contractor hereunder, on the basis of ethnicity, race, age, religion, creed, color, national origin, ancestry, sex, gender, sexual orientation, physical or mental disability, medical condition, or citizenship status.

21. SEVERABILITY

In case any one or more of the provisions contained in this Agreement or any application thereof shall be invalid, illegal or unenforceable in any respect, the validity, legality, and enforceability of the remaining provisions contained herein and any other application thereof shall not in any way be affected or impaired thereby.

22. NOTICES

Any notices required to be given under this Agreement shall be in writing and served by personal delivery or by mail, postage prepaid, to the parties at the following addresses:

City of Santa Fe:
Benefits Department
P.O. Box 909
Santa Fe, NM 87504-0909

Contractor:
Life Insurance North America
3900 E. Mexico Ave. Suite 1200
Denver, CO 80210

IN WITNESS WHEREOF, the parties have executed this Agreement on the date set forth below.

CITY OF SANTA FE:

_____
DAVID COSS, MAYOR
DATE:_____

ATTEST:

_____
YOLANDA Y. VIGIL, CITY CLERK

CONTRACTOR:
LIFE INSURANCE NORTH AMERICA

APPROVED AS TO FORM:

By:_____
(Name & Title)

Judith Amer for
GENO ZAMORA, CITY ATTORNEY
6/6/11

Title:_____

Date:_____
CRS#02-266643005
City of Santa Fe Business Registration # 11-00105480

APPROVED:

_____
KATHRYN RAVELING, FINANCE DEPARTMENT
62107.510300
Business Unit Line Item

Group Disability, Life and Accident Implementation Welcome Package

Welcome to CIGNA Group Insurance! This package contains a group of forms and documents necessary for the implementation of your CIGNA Group Insurance Disability, Life and/or Accident insurance benefits. We've included a chart that provides a description of each document and clarifies your action required. To assure operational readiness and accurate set-up of your benefit plan(s) please complete this application by signing in the space provided.

Applicant (Full Legal Name): City of Santa Fe

Address: 200 Lincoln Ave. **City:** Santa Fe **State:** NM **Zip Code:** 87504

Taxpayer ID No.: 85-6000168

We acknowledge receipt of this Implementation Welcome Package. We confirm the accuracy of the proposal from the underwriting company(ies) named below and hereby accept the terms and conditions of the proposal and any attachments or modifications made to the proposal.

If applicable, we authorize LINA Benefit Payments, Inc. to perform the tax services related to our disability benefits as described within the attached Limited Agency Agreement (Exhibit).

If applicable, we authorize LINA to perform the benefit deduction services related to our disability benefits as described within the attached Benefit Deduction Services Agreement (Exhibit).

We confirm appointment of the producer identified on the attached Authorization of Payment of Commission and Service Fees (Exhibit)

We acknowledge receipt of the Privacy Notice.

We understand that the following insurance policies may be issued to the Group Insurance Trust for Employers in the Public Administration Industry.

REQUESTED INSURANCE	REQUESTED EFFECTIVE DATE
COVERAGE: Basic & Voluntary Group Term Life **UNDERWRITING COMPANY: Life Insurance Company of North America**	**7/1/2011**
COVERAGE: Basic & Voluntary AD&D **UNDERWRITING COMPANY: Life Insurance Company of North America**	**7/1/2011**

We hereby adopt the above-named trust as co-settlor and subscribe to that trust for the purpose of participating in these policies, which shall only cover our eligible employees, and, if applicable, retirees and dependents. We confirm the appointment of Wilmington Trust Company as Trustee, and of Life Insurance Company of North America ("LINA") as trust administrator. We appoint LINA, in its capacity as trust administrator, to represent us in dealings with the Trustee related to the insurance trust. We understand that, in the event the policy(ies) are terminated for any reason, we will cease to be a participant in the insurance trust. We understand that no benefits are provided by the trust other than the benefits described in the insurance policy(ies).

_____ Date: _____

(Signature and Title of Applicant's Authorized Representative)

Santa Fe, NM
(City and State)

ATTACHMENTS FOR CUSTOMER REVIEW AND/OR ACKNOWLEDGEMENT			
Welcome Package Form	***Purpose of Form***	***Specific to Product Line***	***Action Required***
Emergency Travel Assistance Services Agreement	Provides overview of the services being provided by Europ Assistance USA, Inc. and agreement to provide these services to the policyholder.	Accidental Death & Dismemberment Coverages	Please review.
Identity Theft Service Agreement	Provides overview of the services being provided by Europ Assistance USA, Inc. and agreement to provide these services to the policyholder.	Accidental Death & Dismemberment Coverages	Please review.
Disclosure of Payment of Commissions and Service Fees (Exhibit)	Contains important disclosures regarding commissions and other producer compensation.	All Applicable Policies	Please review.
Non-Standard ADEA Notice	Confirm request to use a schedule which reduces or terminates benefits on the basis of age which differ from those provisions or schedules customarily used by the insurance company.	Life Policies	Please review
Privacy Notice	Provides an overview of CIGNA Group Insurance's privacy policies	All Policies	Please review.
CUSTOMER ITEMS TO PROVIDE			
Binder Check Invoice	Invoice to support estimated binder check amount on basic coverages only. Binder amount will be applied to first month's premium.	All Coverages	Supply Binder Check with copy of the provided Invoice
ATTACHMENTS REQUIRING ADDITIONAL SIGNATURES			
Welcome Package Form	***Purpose of Form***	***Specific to Product Line***	***Action Required***
CIGNA Claim Fiduciary Appointment Form	If your employee benefit plans are subject to ERISA, and insured with our companies, you should review this information, and sign and return the enclosed "Appointment of Claim Fiduciary." If your employee benefit plans are not subject to ERISA (for example, if they are government plans or church plans), then this information does not apply to you.	All Policies (when applicable)	Please have form signed by an individual authorized to amend the Plan.

CIGNA Secure Travel®

EMERGENCY TRAVEL ASSISTANCE SERVICES

Services provided by Europ Assistance USA, Inc.

Subscriber: City of Santa Fe

Membership No.: 57

The following is a description of the Emergency Travel Assistance Services ("Services") provided by Europ Assistance USA, Inc. ("EA") through the CIGNA Secure Travel® program. The cost of these services is included within the premium for the Policy identified above. Services will be provided only while the Policy is in force and while the master agreement between EA and Life Insurance Company of North America ("Insurance Company") is in effect. The Insurance Company reserves the right to modify the scope or availability of services, or to terminate the master agreement between EA and the Insurance Company, upon written notice to the Subscriber. Subscriber ("Subscriber") is defined as a company that has purchased the CIGNA Secure Travel Program for its employees.

Covered Members – Employees of the Subscriber insured under the Policy, including any dependents insured under the Policy, shall be eligible for CIGNA Secure Travel® services, whenever traveling 100 miles or more from their permanent residence ("Covered Members"). Service will also be available for pre-trip information just prior to a trip meeting the above requirements.

Access To Services – To gain access to CIGNA Secure Travel® services, a Covered Member must contact EA.

Eligibility for Services- EA will verify eligibility via a roster provided by the Insurance Company. If the Subscriber is not listed in the roster, EA will verify with the Insurance Company's designated official that the Covered Member is employed by the Subscriber.

The Subscriber shall designate an authorized company official to verify to EA that the Covered Member is employed by the Subscriber. The Subscriber must provide EA with sufficient information to make contact with the designated authorized company official at all times. Once employment is verified, EA is authorized to provide services and the Covered Member shall be responsible for all third party costs incurred by EA in providing authorized services, with the exception of those costs incurred for the medical evacuation and repatriation services covered under the CIGNA Secure Travel program.

If contact is made outside of business hours, EA will render services but shall not be responsible for any claim, damage, loss, cost, liability or expense which arises in whole or in part as a result of EA's inability to contact the designated company official for any reason beyond EA's control or as a result of the failure or refusal of the Subscriber to authorize the services proposed by EA.

Authorized services shall include services provided by EA in response to contact with EA made by Covered Member after normal business hours, at a time when EA is unable to verify eligibility.

24 Hour Access – Covered Members will be able to reach EA's multilingual coordination center in Washington, D.C. toll-free by telephone, telex, and facsimile 24 hours a day, 365 days a year to confirm coverage and obtain access to the following services.

I. Informational Assistance

Prior to a trip, Covered Members can contact EA for up-to-date information on the following:

1. **Inoculation and Visa Information** – Information concerning visa and inoculation requirements of the foreign countries in which members are traveling.

2. **Cultural Information** – Information concerning cultural and special events, if available, in the areas to which Covered Members are traveling.

3. **Temperature and Weather Information** – Weather forecasts and temperatures for major cities around the world as well as domestic and international ski reports for major ski areas.

4. **Embassy and Consular Referral** – Addresses and telephone numbers of the nearest American Consulate and Embassies, as appropriate.

5. **Foreign Exchange Rates –** Information on foreign exchange rates between the U.S. and most major currencies. These rates are updated on a daily basis. The rates may vary slightly from rates posted by local financial institutions and are meant as general guidelines.

II. Emergency Medical Assistance

EA is responsible for providing the emergency medical assistance services described in this section. The Insurance Company is responsible for the reimbursement of all costs associated with the following services to EA: emergency medical transport, return of dependent children/ travel companion, visit of a family member/friend and repatriation services.

Location of Medical Providers – Upon a Covered Member's request, EA will provide the names, addresses and telephone numbers of physicians, hospitals, dentists, and dental clinics in the area in which the Covered Member is traveling. EA will also attempt to confirm the availability of the provider, ascertain required payments which a Covered Member will be required to pay, and make an appointment for a Covered Member with the medical provider of the Covered Member's choice. Except as specifically provided in this agreement, expenses of medical care are not insured by the Insurance Company.

Neither EA nor the Insurance Company guarantees the quality of the medical services provider or the medical facility and the final selection of a local physician or medical facility is the Covered Member's right and responsibility.

Medical Monitoring – When notified of a Covered Member's medical emergency resulting from an accident or sickness, EA's multilingual staff will, whenever appropriate in the judgment of EA or a physician designated by EA, attempt to contact the Covered Member and Covered Member's local attending medical personnel in order to attempt to obtain a full understanding of the Covered Member's situation and to attempt to monitor the Covered Member's condition.
EA will continue to monitor the Covered Member's condition and will remain in communication with the Covered Member's family until the Covered Member's medical problem is resolved or the Covered Member has returned home.

Emergency Medical Transport – In the event of a medical emergency, when a Covered Member requests, and a physician designated by EA in consultation with a local attending physician determines that it is medically necessary for a Covered Member to be transported under medical supervision to a different hospital or treatment facility or be repatriated to his/her place of residence for treatment, EA will arrange for the medical evacuation or repatriation under proper medical supervision.

As part of a medical evacuation, EA will also make all necessary arrangements for ground transportation to and from the hospital, as well as pre-admission arrangements, where possible, at the receiving hospital.

All decisions as to the medical need for evacuation or repatriation, the means and timing of any evacuation, the medical equipment and the medical personnel to be used and the final destination are medical decisions that will be made by EA's designated physicians in consultation with a local attending physician based on medical factors and their decisions shall be conclusive in determining the need for such services. Costs of medical evacuation or repatriation are covered under the CIGNA Secure Travel program, provided the foregoing requirements are met.

Return of Dependent Children – If any dependent children under the age of 16 traveling with a Covered Member are left unattended by an adult because the Covered Member is hospitalized, EA will arrange for their transportation home. Should transportation with an attendant be necessary, EA will arrange a qualified escort to accompany the children. The cost of these services are covered under the CIGNA Secure Travel program.

Return of Traveling Companion – If a Covered Member's traveling companion loses previously made travel arrangements due to a delay caused by the Covered Member's medical emergency, EA will help arrange for the traveling companion's return to the companion's original destination. The costs of these services are covered under the CIGNA Secure Travel program.

Visit of a Family Member or Friend – If a Covered Member is traveling alone and must be hospitalized for ten (10) or more consecutive days, EA will arrange for a round-trip economy class transportation for a member of the Covered Member's immediate family, or a friend designated by the Covered Member, from the family member's or friend's home to the place where the Covered Member is hospitalized. EA will also arrange for meals and accommodations (up to $100 per day for up to 7 days) for the family member or friend while they are visiting the hospitalized Covered Member. The costs of these services are covered under the CIGNA Secure Travel program.

Emergency Medical Payments – When necessary to obtain needed medical services for a Covered Member, upon request EA will advance up to $10,000.00 to cover on-site medical expenses, upon receipt of satisfactory guarantee of reimbursement from the Covered Member. Except as specifically provided in this agreement, expenses of medical care are not insured by the Insurance Company.

Repatriation Special Services – In the event a Covered Member dies, EA will arrange for all necessary government authorization required by law, including a container appropriate for transportation and arrange for the repatriation of the remains to the Covered Member's place of residence for burial. The costs of these services are covered under the CIGNA Secure Travel program.

Replacement of Medication – If a Covered Member has an unexpected need for prescription medication or loses, forgets, or runs out of prescription medication while traveling, EA will attempt to locate the medication or its equivalent and attempt to arrange for the Covered Member to obtain it locally, where it is available; or, if not available locally, to have it shipped to the Covered Member, at the Covered Member's expense, subject to local laws. The Covered Member will be provided with a cost estimate for the replacement medication and shipment costs, which shall be subject to Covered Member's approval. Except as specifically provided in this agreement, expenses of medical care are not insured by the Insurance Company.

III. Travel and Communication Assistance

Telephone Interpretation Service – If a Covered Member needs help communicating in an emergency, EA will provide telephonic interpretation services in all major languages. In emergency situations which require extensive translation, EA will make referrals to local translators.

Transmission and Retention of Urgent Messages – In an emergency, EA will use its best efforts to transmit an urgent message for a Covered Member to the Covered Member's family, friends, or business associates. EA will also accept and retain messages for Covered Members at the Europ Assistance North American Coordination Center for up to fifteen (15) days.

Travel Arrangements – In the event of an emergency, EA will help Covered Members make emergency travel arrangements, including airline, hotel, and car rental reservations. The Covered Member is responsible for payment for all tickets, accommodations and rentals arranged.

Lost Luggage, Documents and Personal Items – If a Covered Member's luggage, personal items or travel documents have been lost or stolen, EA will contact the appropriate authorities in order to locate the lost items and have them sent to the Covered Member. If requested, EA will help a Covered Member secure replacement items from home. All shipping and replacement costs are the responsibility of the Covered Member.

Legal Assistance/Bail – In an emergency, EA will attempt to help a Covered Member secure and post bail bonds worldwide, where permitted by local law, from funds forwarded to EA from the Covered Member's family or representative, or with a satisfactory guarantee of reimbursement. EA will also use its best efforts to provide a Covered Member with the names, addresses and telephone numbers of lawyers in the area in which the Covered Member is traveling in case of a car accident, traffic violations, and other offenses. However, the selection of and the expenses associated with a particular attorney are the responsibility of the Covered Member.

Emergency Cash Advance – In an emergency situation, and with the consent of the Covered Member, EA will advance up to $1,500.00, upon satisfactory guarantee of reimbursement.

IV. Limitations

The services described here are available in every country. Some countries, however, may present political and other obstacles that may render assistance services difficult or impossible and services cannot always be guaranteed. Should a Covered Member travel in any area in which there is a rebellion, riot, military uprising, war, labor disturbance or strike, EA will endeavor to provide such services as EA believes it can safely perform under existing conditions.

The medical professionals or attorneys suggested or designated by EA who provide direct services pursuant to this agreement are not employees or agents of EA and, therefore, neither EA nor the Insurance Company is not responsible or liable for their negligence or other acts or omissions.

"CIGNA," and the "Tree of Life" logo are registered service marks of CIGNA Intellectual Property, Inc., licensed for use by CIGNA Corporation and its operating subsidiaries. All products and services are provided exclusively by such operating subsidiaries and not by CIGNA Corporation. Such operating subsidiaries include Life Insurance Company of North America, CIGNA Life Insurance Company of New York, and Connecticut General Life Insurance Company.

CIGNA SecureTravel® program is provided under a contract with Europ Assistance USA, Inc.

ID THEFT RESOLUTION SERVICES

Services provided by Europ Assistance USA, Inc.

Subscriber: City of Santa Fe

Program Description for CIGNA Accident Customers

What is Identity Theft?

"Identity Theft" occurs when someone uses your personal identifying information, like your name, Social Security number, or credit card number, without your permission, to commit fraud or other crimes.

Overview of the Program:

Identity Theft services are provided to CIGNA's accident insurance customers by Europ Assistance USA (EA). EA treats each Identify Theft as an emergency and, subject to the limitations set forth in this Program Description, performs, for the Covered Member any or all of the following steps necessary to attempt to undo or prevent further damage upon receipt, by the Covered Member, of a duly completed and executed "Authorization Form":

- Obtain all pertinent credit information and history from the Covered Member on the phone to determine if an Identity Theft incident has occurred.
- Educate the Covered Member on how Identity Theft occurs and inform him or her of protective measures to take to avoid further occurrences.
- Provide the Covered Member with a helpful *Identity Theft Resolution Kit.*
- Provide the Covered Member with a uniform Identity Theft Affidavit ("Affidavit"), and answer any question with regard to completing the Affidavit. It is the Covered Member's responsibility to submit the Affidavit to the proper authorities, credit bureaus, and creditors.
- Assist the Covered Member with canceling credit and charge card and requesting replacements.
- Assist the Covered Member with notification of all three major credit-reporting agencies to obtain a free credit report for the Covered Member and to place an alert on the Covered Member's records with the agencies.
- Translate whenever necessary such as when caller is overseas and needs help communicating with the local police in order to file a report of an Identity Theft incident.
- Provide the Covered Member with sample letters for his or her use in canceling accounts and resolving issues.
- Provide emergency cash advance (up to $1,000) when a Covered Member's wallet or purse is lost or stolen, 100 miles or more away from the Covered Member's primary place of residence. Such cash advance shall be secured by a valid credit card. Any advance made to the Covered Member, not otherwise secured by a valid credit card and paid to EA by the credit card company within 30 days of such advance, has to be reimbursed by the Covered Member to EA within 30 days from the date such advance is made. Thereafter any amount due will earn interest at a rate of 1.5% per month. EA shall be under no obligation to advance funds not otherwise secured by a valid credit card.

Eligibility Verification:

Covered Members – Employees of the Subscriber insured under the CIGNA Accident Policy, including any dependents insured under the Policy, shall be eligible for Identity Theft Resolution Services. To gain access to services, a Covered Member must contact EA at 888-226-4567.

Eligibility for Services- EA will verify eligibility via a roster provided by CIGNA. If the Subscriber is not listed in the roster, EA will verify with the CIGNA's designated official that the Covered Member is covered under the program.

24 Hour Access – Covered Members will be able to reach EA's multilingual coordination center in Washington, D.C. by toll-free phone 24 hours a day, 365 days a year to obtain access to Identity Theft Resolution services.

Limitations:

Only Covered Members are eligible for these services. Identity Theft(s) discovered by the Covered Member prior to enrollment in the Program are not eligible for service.

Neither EA nor CIGNA guarantees that EA's intervention on behalf of the Covered Member will result in a particular outcome or that EA's efforts on behalf of the Covered Member will lead to a result satisfactory to the Covered Member.

EA Services do not include, and EA shall not assist the Covered Member for thefts involving non-U.S. accounts.

Services are provided by Europ Assistance USA, US office of Europ Assistance.

CIGNA reserves the right to terminate these services upon written notice.

CIGNA Group Insurance
Life · Accident · Disability

Disclosure of Payment of Commissions and Service Fees

We have appointed AON Risk Insurance Services West, Inc. as our broker/consultant of record in connection with the policy, as of its effective date, and continuing unless and until we notify the insurance company in writing of revocation of this appointment. Any revocation of appointment, or designation of a new broker/consultant of record, will become effective on the date written notice is received by the insurance company, or such later date as we specify.

We acknowledge that the insurance company will pay commissions to the broker/consultant at the following rates:

Product	**Policy Numbers**
Life	FLX 964128
Accident	OK 965745

Product		**Percentage**
Life	Case Specific	0%
Effective Date: 7/1/2011		
Accident	Case Specific	0%
Effective Date: 7/1/2011		

We understand and acknowledge that CIGNA Group Insurance companies may have entered into, or may enter into, an agreement with the broker/consultant, under which the insurance company compensates the broker/consultant for providing marketplace intelligence and other services intended to enhance the effectiveness of the insurance company's business. This additional compensation is contingent on meeting new business and persistency goals.

The following describes the compensation available under the program under which your broker is eligible to participate. Terms of the program are subject to change.

- **New Business.** Payments made are a percentage of total annualized premium, based on number of new cases sold and annualized premium for those eligible cases, and range from 1.5% to 4% of the amount of expected first year annualized premium (which is the maximum rate payable, if at least $10,000,000 in premium, is sold) depending on the specific program the broker is eligible to participate in. Brokers must write at least $200,000 of new business premium or sell three new cases to qualify.

- **New Premium Added to Inforce Policies.** Payments made are a percentage of total annualized premiums attributable to acquisitions requiring underwriting by the insurance company, and amendments to increase benefits or add eligible classes, and is calculated at 1.5% of the amount of expected first year annualized premium depending on the specific program the broker is eligible to participate in. Brokers must write at least $200,000 of new business premium or sell three new cases to qualify.

- **Persistency**. Persistency measures the number of policies (weighted by premium) which were in force at the beginning of the year which are still in force at the end of the year. Payments made are a percentage of total earned premium, and range from 0% to 2% of total aggregate premium for those eligible cases (which is the maximum rate payable, if persistency is 95% or greater) depending on the specific program the broker is eligible to participate in. Brokers must have a book of business of at least $250,000 at the start of the year, and write at least $200,000 of new business premium or sell three new cases, to qualify.

- **Cross-Sell.** Payments made are a percentage of total annualized premium for business sold to an existing CIGNA Healthcare or CIGNA International Expatriate Benefits customer OR sold along with a new CIGNA Healthcare medical product or new CIGNA International Expatriate Benefits product to the same customer, and range from 1% to 1.5% of the amount of expected first year annualized premium (which is the maximum rate payable, if at

least $1,000,000 in premium, is sold). Brokers must write at least $50,000 of new business premium to a cross-sell customer to qualify. In addition, your policies may be used to establish eligibility in the cross-sell programs of CIGNA Healthcare and/or CIGNA International Expatriate Benefits.

This compensation is funded from the insurance company's overhead and is based on the broker's overall book of business with the insurance company. Any such payments are separate from commissions and, if applicable, will be included in ERISA Form 5500, Schedule A information provided by the insurance company.

We also understand that the insurance company may invite the broker to participate in events sponsored by the insurance company for the same purposes.

CIGNA Group Insurance
Life · Accident · Disability

May 20, 2011

City of Santa Fe
200 Lincoln Ave.
Santa Fe, NM 87504

RE: Group Policy Number - **FLX 964128**
Benefit Reduction/Limitation Schedule(s)

Dear City of Santa Fe:

You have requested that the Life Insurance Company of North America ("LINA"), a CIGNA company, issue a group insurance policy ("Policy") to City of Santa Fe, which contains provisions or schedules reducing or terminating benefits on the basis of age which differ from those provisions or schedules customarily used by LINA.

The purpose of this letter is to confirm with you that your request has not been made on the basis of or in reliance on any representations or warranties provided by LINA that such provisions or schedules meet the requirements of any applicable federal or state employment discrimination laws, including the federal Age Discrimination in Employment Act. While it is recommended that you seek the advice of your legal counsel to ensure compliance with any applicable employment discrimination laws, you nonetheless agree to assume full responsibility for the compliance with the requirements of such laws to the extent they are applicable to the employee benefit plans of which the Policy is a part.

Cordially,

Melissa Berge
Implementation Coordinator
CIGNA Group Insurance
3900 E. Mexico Avenue, Suite 1200
Denver, CO 80210
Phone: 303.691.1029
Fax: 646.406.4220
Melissa.Berge@CIGNA.com

Important Privacy Notice – Please Read

As a customer of a CIGNA company[1], we want to assure you that we recognize our obligation to keep our customers' protected information secure and confidential. This notice explains our privacy practices and it should answer questions about how we protect personal information. We will continue to safeguard the privacy of the information provided to us. Thank you for giving us the opportunity to serve you. (If you are an Employer or Group Sponsor, please make this information available for review by your employees or members as appropriate.)

This notice applies to insurance products underwritten, or administered by, the Life Insurance Company of North America and CIGNA Life Insurance Company of New York, Life and Disability products underwritten by Connecticut General Life Insurance Company, and insurance products underwritten by Insurance Company of North America administered by the CIGNA companies. Information is the key to our ability to provide you with best in class service. Regardless of whether you are a customer, applicant, insured, or former insured, we are committed to protecting and maintaining the privacy of any information in our possession.

COLLECTION AND USE OF INFORMATION

We may collect protected information about our customers for use in the processing and evaluation of applications or eligibility for insurance, investigating a claim for benefits, and in developing financial plans. This information will be used by authorized company personnel solely for these purposes, and it may be integrated into our databases for statistical and audit purposes. Protected information means any non-public, personally identifiable information including financial information, employment related information and medical information. Unless permitted by law, we will only collect information from sources other than our customers with authorization.

DISCLOSURE OF INFORMATION

We do not disclose any protected information about our customers or former customers to anyone except as permitted by law. We do not sell customer lists or other protected information. With some exceptions, we will not disclose protected information without written authorization. There are circumstances when we will disclose protected information related to medical underwriting or a claim investigation or other activities relating to your insurance plan without authorization to third parties or affiliates assisting us with these activities, as permitted by law. We will also disclose protected information to third parties without authorization as required by law, such as in the case of subpoenas and mandated governmental disclosures.

PROTECTING YOUR INFORMATION

We have internal policies to maintain the privacy of our customers' protected information. These include but are not limited to policies related to the transmission, storage and disposal of paper and electronic information; the prevention of unauthorized access and damage to systems, including damage due to environmental hazards; and assigning and terminating user IDs.

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[1] "CIGNA" is a registered trademark licensed for the use of insurance company subsidiaries of CIGNA Corporation. All products and services are provided by insurance company subsidiaries and not the corporation itself. As used herein, "CIGNA" refers to these subsidiaries, which include the Life Insurance Company of North America, CIGNA Life Insurance Company of New York and Connecticut General Life Insurance Company.

BINDER CHECK INVOICE

Life Insurance Company of North America

City of Santa Fe
200 Lincoln Ave.
Santa Fe, NM 87504

Policy Number	Effective Date	Description	Total Due
FLX 964128	7/1/2011	**Group Term Life**	**$882.00**
OK 965745	7/1/2011	**Basic & Voluntary AD&D**	**$556.00**
		TOTAL DUE:	**$1,438.00**

Make check payable to Life Insurance Company of North America

Include a copy of this invoice with your *initial* payment and mail to the address below.

Life Insurance Company of North America
P.O. Box 8500 K 110
Philadelphia, PA 19178-0110

PLEASE NOTIFY US IMMEDIATELY OF ANY CORRECTIONS IN THIS STATEMENT

CIGNA Group Insurance
Life · Accident · Disability

ERISA COVERAGE WORKSHEET

Use this worksheet to determine whether a policy is issued in conjunction with ERISA. Where a policy is issued in conjunction with ERISA, the following will apply:

1. The insurance company will serve as the employer's named fiduciary for handling claims in accordance with ERISA regulations. The "Appointment of Claim Fiduciary" is required.

2. Certificates of insurance will be prepared with ERISA Summary Plan Description wording included.

3. Information will be provided for the ERISA Annual Report, Form 5500, Schedule A.

4. Claim-related correspondence will comply with ERISA requirements, including notification of rights granted by ERISA regulations.

Name of Policyholder: City of Santa Fe

		Effective Date:
Life Policy No(s):	FLX 964128	7/1/2011
Accident Policy No(s):	OK 965745	7/1/2011

In general, any group insurance policy issued to an employer to insure employees, or to a labor union to insure union members, is subject to ERISA. **All policies will be considered to be subject to ERISA unless one of the following exemptions applies.**

☐ The policy is not issued to insure employees of an employer, or members of a labor union.

☐ The policy is a statutory disability policy (e.g. Hawaii, New Jersey, New York).

☒ The policyholder is a government employer (e.g. state, county, city, special services district, public school district, public hospital, state college or university).

☐ The policyholder is a church group (religious organization, or hospital, school, or college operated by a religious organization) which has not made an election under IRC Section 410(d) to be subject to ERISA.

☐ The plan is a short-term, uninsured salary continuance plan funded with general assets of the employer.

☐ The plan is voluntary, funded entirely with employee contributions, and is not enrolled or endorsed by the employer; employer participation is limited to permitting the insurance company to conduct enrollments, and handling payroll deductions.

☐ None of the above exemptions apply. The policy is issued as part of an ERISA-covered employee benefit plan. **If this is the case, then the Policyholder should sign the next page, "Appointment of Claim Fiduciary," instead of this page.**

Implementation Coordinator

Policyholder Representative

ITEM # 15-0757

Administrative Services Only Agreement

By and Between

City of Santa Fe
"Employer"

And

Cigna Health and Life Insurance Company
"CHLIC"

Effective Date: July 1, 2015

THIS AGREEMENT AND ITS TERMS ARE PROPRIETARY AND CANNOT BE DISCLOSED WITHOUT THE PERMISSION OF EACH OF THE PARTIES

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THIS AGREEMENT, effective July 1, 2015 (the "**Effective Date**") is by and between City of Santa Fe ("**Employer**") and Cigna Health and Life Insurance Company ("**CHLIC**").

RECITALS:

WHEREAS, Employer, as Plan sponsor, has adopted the benefit described in Exhibit A, as may be amended, ("**Plan**") for certain of its employees/members and their eligible dependents (collectively "**Members**"); and

WHEREAS, Employer has requested CHLIC to furnish certain administration services in connection with the Plan 3338881.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, it is hereby agreed as follows:

Definitions

Agreement – this entire document including the Schedule of Financial Charges and all Exhibits.

Applicable Law – means the state, federal and international laws and regulations that apply. Applicable Law includes but is not limited to the Employee Retirement Income Security Act of 1974, as amended and the rules and regulations thereunder ("**ERISA**"), the Health Insurance Portability and Accountability Act of 1996, as amended and the rules and regulations thereunder ("**HIPAA**"), the Foreign Corrupt Practices Act ("**FCPA**") and any other anti-bribery or anti-corruption laws in the countries where the Parties conduct business.

Bank Account – a benefit plan account with a bank designated by CHLIC; established and maintained by Employer in its or a nominee's name.

ERISA – the Employee Retirement Income Security Act of 1974, as amended and related regulations.

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

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

Participant/Participating Members – Member(s) who is (are) participating in a specific program and/or product available to Members under the Plan.

Participating Providers – providers of health care services and/or products, who/which contract directly or indirectly with CHLIC to provide services and/or products to Members.

Plan Benefits – Amounts payable for covered health care services and products under the terms of the Plan.

Party/Parties – refers to Employer and CHLIC, each a "Party" and collectively, the "Parties".

Plan Year – the twelve (12) month period, beginning on the Effective Date and, thereafter, each subsequent twelve (12) month period.

Run-Out Claims – claims for Plan Benefits relating to health care services and products that are incurred prior to termination of this Agreement; termination of a Plan benefit option or termination of eligible Members, as applicable.

Section 1. Term and Termination of Agreement

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

i. The date which is at least sixty (60) days from the date that either Party provides written notice to the other Party of termination of this Agreement;

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

iii. The date upon which Employer fails to fund the Bank Account as required by this Agreement or fails to pay CHLIC any charges identified in this Agreement when due provided CHLIC notifies Employer of its election to terminate;

iv. Any other date mutually agreed upon by the Parties.

Section 2. Claim Administration and Additional Services

a. While this Agreement is in effect, CHLIC shall, consistent with, the claim administration policies and procedures then applicable to its own health care insurance business (i) receive and review claims for Plan Benefits; (ii) determine the Plan Benefits, if any, payable for such claims; (iii) disburse payments of Plan Benefits to claimants; and (iv) provide in the manner and within the time limits required by Applicable Law, notification to claimants of (a) the coverage determination or (b) any anticipated delay in making a coverage determination beyond the time required by Applicable Law.

b. Following (i) termination of this Agreement, except pursuant to Section 1 (iii); (ii) termination of a Plan benefit option or (iii) termination of eligible Members, if the required fees have been paid in full, if any, CHLIC shall process Run-Out Claims for the applicable Run-Out Period (Refer to Schedule of Financial Charges for applicable fees and Run-Out Period). At the termination of any applicable Run-Out Period, CHLIC shall cease processing Run-Out Claims and, subject to the requirements of Section 6.b, make all relevant records in its possession relating to such claims reasonably available to Employer or Employer's designee. CHLIC is not required to provide proprietary information to Employer or any other party.

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

d. In addition to the basic claim administrative duties described above, CHLIC shall also perform the Plan-related administrative duties agreed upon by the Parties and specified in Exhibit B. All services identified in this Agreement shall be provided by CHLIC on an exclusive basis unless otherwise agreed to in writing by CHLIC.

Section 3. Funding and Payment of Claims

a. Employer shall establish a Bank Account, and maintain in the Bank Account an amount sufficient at all times to fund checks written on it for the following (collectively "**Bank Account Payments**"): (i) Plan Benefits; (ii) those charges and fees identified in the Schedule of Financial Charges as payable through the Bank Account and (iii) any sales or use taxes, or any similar benefit- or Plan-related charge or assessment however denominated, which may be imposed by any governmental authority. Bank Account Payments may include without limitation: (i) fixed per

person payments and pay-for-performance incentive payments to Participating Providers; (ii) amounts owed to CHLIC; and (iii) amounts paid to CHLIC's affiliates and/or subcontractors for, among other things, network access or in- and out-of network health care services/products provided to Members. CHLIC may credit the Bank Account with payments due Employer under a stop loss policy issued by CHLIC or an affiliate.

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

c. In the event that sufficient funds are not available in the Bank Account to pay all Bank Account Payments when due, CHLIC shall cease to process claims for Plan Benefits including Run-Out Claims.

d. CHLIC will promptly adjust any underpayment of Plan Benefits by drawing additional funds due the claimant from the Bank Account. In the event CHLIC overpays a claim for Plan Benefits or pays Plan Benefits to the wrong party, it shall take all reasonable steps to recover the overpayments. CHLIC shall not be required to initiate court, mediation, arbitration or other administrative proceedings to recover any overpayment, but where it elects to do so. CHLIC is expressly authorized by Employer to take all actions on behalf of the Employer and/or the Plan to pursue recovery, including, but not limited to, retaining counsel, settling and compromising claims, in which case CHLIC shall be responsible for the attorney fees, court costs or arbitration fees incurred by CHLIC in the specific recovery action, but not any other associated third party costs absent consent of CHLIC. CHLIC shall not be responsible for reimbursing any unrecovered payments of Plan Benefits unless made as a result of its gross negligence or intentional wrongdoing.

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

f. Following termination of this Agreement, Employer shall remain liable for payment of all due Bank Account Payments and for all reimbursements due Members under the Plan.

This Section 3 shall survive termination of this Agreement.

Section 4. Charges

a. Charges. CHLIC shall provide to Employer a monthly statement of all charges Employer is obligated to pay under this Agreement that are not paid as Bank Account Payments. Payment of all billed charges shall be due on the first day of the month, as indicated on the monthly statement. b. Member Changes – Additions and Terminations. If a Member's effective date is on or before the fifteenth (15th) day of the month, full charges applicable to that Member shall be due for that Member for that month. If coverage does not start or ceases on or before the fifteenth (15th) day of the month for a Member, no charges shall be due for that Member for that month.

c. Retroactive Member Changes and Terminations. Employer shall remain responsible for all charges and Bank Account Payments incurred or charged through the date CHLIC processed Employer's notice of a retroactive change or termination of Membership. However, if the change or termination would result in a reduction in charges, CHLIC shall credit to Employer the reduction in charges charged for the shorter of (a) the sixty (60) day period preceding the date CHLIC processes the notice, or (b) the period from the date of the change or termination to the date CHLIC processes the notice.

This Section 4 shall survive termination of this Agreement.

Section 5. Enrollment and Determination of Eligibility

a. Eligibility Determinations and Information. Employer is responsible for administering Plan enrollment. In determining any person's right to benefits under the Plan, CHLIC shall rely upon enrollment and eligibility

information provided by the Employer. Such information shall identify the effective date of eligibility and the termination date of eligibility and shall be provided promptly to CHLIC in a format and with such other information as reasonably may be required by CHLIC for the proper administration of the Plan.

b. Release of Liability. Notwithstanding any inconsistent provision of this Agreement to the contrary, if Employer, fails to provide CHLIC with accurate enrollment and eligibility information, benefit design requirements, or other agreed-upon information in CHLIC's standard timeframe and format, CHLIC shall have no liability under this Agreement for any act or omission by CHLIC, or its employees, affiliates, subcontractors, agents or representatives, directly or indirectly caused by such failure.

c. Reconciliation of Eligibility and Information and Default Terminations. CHLIC will periodically share potential discrepancies in eligibility information with Employer. Employer will review and reconcile any discrepancies within thirty (30) days of receipt. If Employer fails to timely do so, CHLIC may terminate coverage for any Member not listed as eligible in Employer's submitted eligibility information.

Section 6. Claim Audits and Confidentiality

a. Claim Audit. Employer may, in accordance with the following requirements and at no additional charge while this Agreement is in effect, audit CHLIC's payment of Plan Benefits subject to the following conditions:

i. Employer shall provide to CHLIC a scope of audit letter and the fully executed Claim Audit Agreement, a sample of which is attached hereto as Exhibit C, together with a forty-five (45) day advance written request for audit. Employer will designate with CHLIC's consent, such consent not to be unreasonably withheld, an independent, third party auditor to conduct the audit (the "**Auditor**"). In addition, Employer and CHLIC will agree upon the date for the audit during regular business hours at CHLIC's office(s). Employer shall be responsible for its Auditor's costs. The audit shall be conducted in accordance with the terms of CHLIC's Claim Audit Agreement, which is hereby agreed to by Employer and which shall be signed by the Auditor prior to the start of the audit.

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

iii. Auditor will review payment documents (subject to any contrary terms in Participating Provider agreements) relating to a random, statistically valid sample of two-hundred twenty-five (225) claims paid during the two prior Plan years and not previously audited. If the audit identifies any claim adjustments, any such adjustments will be made in accordance with this Agreement and based upon the actual claims reviewed and not upon statistical projections or extrapolations.

b. Confidentiality

i. Subject to the requirements of Applicable Law, the terms of this Agreement and the Privacy Addendum in Exhibit D, a signed Business Associate agreement between Employer and its designee, and a signed Confidentiality Agreement between CHLIC and applicable designee; CHLIC shall release copies of confidential claims and Plan Benefit payment information in CHLIC's claims system ("**Confidential Information**") and may release copies of proprietary information relating to the Plan in CHLIC's claims system ("**Proprietary Information**") to the Employer and/or its designees. Employer agrees that Employer and its designees will keep Confidential Information and Proprietary Information confidential and will use Confidential Information and Proprietary Information solely for the purpose of administering the Plan or as otherwise required by law.

Employer is solely responsible for the consequences of any use, misuse, or disclosure of Confidential Information provided by CHLIC pursuant to this paragraph b.

ii. CHLIC will maintain the confidentiality of all Protected Health Information in its possession in accordance with the Privacy Addendum in Exhibit D and any applicable state privacy laws, including, without limitation, 201 CMR 17.00: Massachusetts Standards for the Protection of Personal Information of Residents of the Commonwealth.

c. Upon termination of this Agreement and subject to the provisions of Section 6.b above, CHLIC shall make information available, to the extent administratively feasible, if the Parties agree upon the charge to be paid by Employer.

The obligations set forth in this Section 6 (b), shall survive termination of this Agreement.

Section 7. Plan Benefit Liability

a. Employer Liability for Plan Benefits. Employer is responsible for all Plan Benefits including any Plan Benefits paid as a result of any legal action. Employer is responsible for reimbursing CHLIC, its directors, officers and employees for any reasonable expense incurred (including reasonable attorneys' fees) by them in the defense of any action or proceeding involving a claim for Plan Benefits. CHLIC shall reasonably cooperate with Employer, in its defense of such actions.

If Employer directs CHLIC in writing to pay a claim for Extra-Contractual Benefits, Employer is responsible for funding the payment and such payments shall not be considered in determining reimbursements or payments under stop loss insurance or in determining any risk-sharing or performance guarantee reimbursements. Employer shall reimburse CHLIC for any liability or expenses (including reasonable attorneys' fees) CHLIC may incur in connection with making such payments.

b. Employer Liability for Plan-Related Expenses. Employer shall reimburse CHLIC for any amounts CHLIC may be required to pay (i) as state premium tax or any similar Plan-related tax, charge, surcharge or assessment, or (ii) under any unclaimed or abandoned property, or escheat law, with respect to Plan Benefits and any penalties and/or interest thereon.

c. Alternative Litigation Management Option. Prior to the beginning of each Plan Year, and contingent upon timely payment by Employer of the associated additional "Claim Litigation Charge" set forth in the Schedule of Financial Charges, Employer may elect to have CHLIC assume responsibility for the management of any claim-related legal action and bear the legal expenses associated with defending such action so long as CHLIC processed the claim(s) in dispute. This option does not extend to actions against Employer and/or CHLIC related to the payment of Extra-Contractual Benefits. Each Party will provide notice to the other of any action and will fully cooperate in the defense of the action unless a potential conflict of interest exists. Nothing in this paragraph (c) shall be read to contravene the explicit terms of 7(a) and 7(b). Employer shall remain responsible for payment of any benefits determined due under the Plan and any damages or penalties assessed in connection with the action.

The reimbursement obligations set forth in this Section 7 shall survive termination of this Agreement.

Section 8. Modification of Plan and Charges

a. CHLIC shall have the right to revise the charges identified in this agreement on the third anniversary of this Agreement (7/1/2018) to the 2% increase agreed to during the proposal process and anytime thereafter by giving the Employer at least 60 days prior written notice but not more frequently than once in a 12 month period and/or

upon any change in law or regulation that materially impacts CHLIC's liabilities and/or responsibilities under this agreement. A revision of the charges shall be considered a modification of the agreement.

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

Section 9. Modification of Agreement

This Agreement constitutes the entire contract between the Parties regarding the subject matter herein. Except, as otherwise provided herein, the provisions of this Agreement shall control in the event of a conflict with the terms of any other agreements. No modification or amendment hereto shall be valid unless in writing and signed by an authorized person of each of the Parties, except that modification of charges pursuant to Section 8 above may be made by written notice to Employer by CHLIC. If Employer pays such revised charges or fails to object to such revision in writing within fifteen (15) days of receipt, this Agreement shall be deemed modified to reflect the charges as communicated by CHLIC.

Section 10. Laws Governing Agreement

a. This Agreement shall be construed in accordance with the laws of the State of New Mexico without regard to conflict of law rules, and both Parties consent to the venue and jurisdiction of its courts.

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

Section 11. Information in CHLIC Processing Systems

CHLIC may retain and use all Plan-related claim and Plan Benefit payment information recorded for or otherwise integrated into CHLIC's business records including claim processing systems during the ordinary course of business (provided, however, that claim or payment information will be available to Employer pursuant to Section 6). CHLIC will retain claim and payment information as required by Applicable Law.

Section 12. Resolution of Disputes

It is understood and agreed that any dispute between the Parties arising from or relating to the performance or interpretation of this Agreement ("**Controversy**") shall be resolved exclusively pursuant to the following mandatory dispute resolution procedures:

a. Any Controversy shall first be referred to an executive level employee of each Party who shall meet and confer with his/her counterpart to attempt to resolve the dispute ("**Executive Review**") as follows: The disputing Party shall initiate Executive Review by giving the other Party written notice of the Controversy and shall specifically request Executive Review of said Controversy in such notice. Within twenty (20) calendar days of any Party's written request for Executive Review, the receiving Party shall submit a written response. Both the notice and response shall include a statement of each Party's position and a summary of the evidence and arguments supporting its position. Within thirty (30) calendar days of any Party's request for Executive Review, an executive level employee of each Party shall be designated by the Party to meet and confer with his/her counterpart to attempt to resolve the dispute. Each representative shall have full authority to resolve the dispute.

b. In the event that a Controversy has not been resolved within thirty-five (35) calendar days of the request of Executive Review under Section 12.a, above, the disputing Party shall initiate mediation by providing written notice to the other Party, which shall be conducted in Hartford, Connecticut, in accordance with the American

Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Mediation ("**Mediation**"). Each Party shall assume its own costs and attorneys' fees, and the compensation and expenses of the mediator and any administrative fees or costs associated with the mediation proceeding shall be borne equally by the Parties.

c. In the event that a Controversy has not been resolved by Executive Review or Mediation, the Controversy shall be settled exclusively by binding arbitration. The arbitration shall be conducted in the same location as noted in Section 12.b. above, in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration, and which to the extent of the subject matter of the arbitration, shall be binding not only on all Parties to this Agreement but on any other entity controlled by, in control of or under common control with the Party to the extent that such affiliate joins in the arbitration, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Each Party shall assume its own costs and attorneys' fees, and the compensation and expenses of the arbitrator and any administrative fees or costs associated with the arbitration proceeding shall be borne equally by the Parties. The decision of the arbitrator shall be final, conclusive and binding, and no action at law or in equity may be instituted by either Party other than to enforce the award of the arbitrator.

d. The Parties intend this dispute resolution procedure described above to be a private undertaking and agree that an arbitration conducted under this provision will not be consolidated with an arbitration involving other plans administered in whole or in part by CHLIC or other Cigna Corporation affiliate, or third parties not parties to this Agreement. The arbitrator will be without power to conduct arbitration on a class or representative basis. The Parties waive their right to participate in a class action or representative proceeding. The arbitrator may award declaratory or injunctive relief only in favor of the individual party seeking relief and only to the extent necessary to provide relief warranted by that party's individual claim. All issues are for the arbitrator to decide, except the courts will decide those issues relating to the scope and enforceability of the arbitration provision.

This Section 12 shall survive termination of this Agreement.

Section 13. Third Party Beneficiaries

This Agreement is solely for the benefit of Employer and CHLIC. It shall not be construed to create any legal relationship between CHLIC and any other party.

Section 14. Waivers

No course of dealing or failure of either Party to strictly enforce any term, right or condition of this Agreement shall be construed as a waiver of such term, right or condition. Waiver by either Party of any default shall not be deemed a waiver of any other default.

Section 15. Headings

Article, section, or paragraph headings contained in this Agreement are for reference purposes only and shall not affect the meaning or interpretation of this Agreement.

Section 16. Severability

If any provision or any part of a provision of this Agreement is held invalid or unenforceable, such invalidity or unenforceability shall not invalidate or render unenforceable any other portion of this Agreement.

Section 17. Force Majeure

CHLIC shall not be liable for any failure to meet any of the obligations required under this Agreement where such failure to perform is due to any contingency beyond the reasonable control of CHLIC, their employees, officers, or directors. Such contingencies include, but are not limited to, acts or omissions of any person or entity not employed or

reasonably controlled by CHLIC, their employees, officers, or directors, acts of God, fires, wars, accidents, labor disputes or shortages, and governmental laws, ordinances, rules or regulations.

Section 18. Assignment and Subcontracting

No Party may assign any right, interest, or obligation hereunder without the express written consent of the other Party; provided, however that CHLIC may assign any right, interest, or responsibility under this Agreement to its affiliates and/or subcontract specific obligations under this Agreement provided that CHLIC shall not be relieved of its obligations under this Agreement when doing so.

Section 19. Notices

Except as otherwise provided, all notices or other communications hereunder shall be in writing and shall be deemed to have been duly made when (a) delivered in person, (b) delivered to an agent, such as an overnight or similar delivery service, (c) delivered electronically, or (d) deposited in the United States mail, postage prepaid, and addressed as follows:

To CHLIC:
Cigna Health and Life Insurance Company
8505 East Orchard Road
Greenwood Village, CO 80111
Attention: Chris Daily, Underwriting Director

To Employer:
City of Santa Fe
200 Lincoln Avenue
Santa Fe, NM 87501
Attention: City Manager

The address to which notices or communications may be given by either Party may be changed by written notice given by one Party to the other pursuant to this Section.

Section 20. Identifying Information and Internet Usage

Except, as necessary in the performance of their duties under this Agreement, no Party may use the other's name, logo, service marks, trademarks or other identifying information or to establish a link to the other's World Wide Web site without its prior written approval.

SIGNATURES

CITY OF SANTA FE:

JAVIER M. GONZALES, MAYOR

DATE: 6/5/15

ATTEST:

YOLANDA Y. VIGIL, CITY CLERK
CC mtg. 4/29/15

APPROVED AS TO FORM:

MDM 5/20

KELLEY A. BRENNAN, CITY ATTORNEY

APPROVED:

6-13-2015

OSCAR RODRIGUEZ, FINANCE DIRECTOR

Business Unit/Line Item: 62107-510300

CIGNA HEALTH AND LIFE INSURANCE CO.

Victoria A. Sirica
Its Contractual Agreement Unit Manager
Duly Authorized

DATE: 7/1/15

Business License:
15-001334434

CRS #: 03-326674003

Schedule of Financial Charges

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

MEDICAL/DENTAL ADMINISTRATION CHARGES		
Product	**Description**	**Charge**
Medical	• Open Access Plus (OAP) with PHS Plus Medical Management	**$33.88/employee/month**
Medical	• HRA Open Access Plus (OAP) with PHS Plus Medical Management (Non-COBRA)	**$38.82/employee/month**
Medical	• HRA Open Access Plus (OAP) with PHS Plus Medical Management (COBRA)	**$37.08/employee/month**
Dental	• Dental Preferred Provider Organization (DPPO)	**$3.45/employee/month**
MEDICAL/DENTAL NETWORK ACCESS FEE, UTILIZATION MANAGEMENT FEE AND OPTIONAL PROGRAM FEE		
Product	**Description**	**Charge**
Medical	• OAP Access Fee	**$17.75/employee/month Included in Medical Administration Charge**
Medical	• HRA OAP Access Fee (Non-COBRA)	**$17.75/employee/month Included in Medical Administration Charge**
Medical	• HRA OAP Access Fee (COBRA)	**$20.95/employee/month Included in Medical Administration Charge**
Dental	• DPPO Access Fee	**$0.80/employee/month Included in Dental Administration Charge**

CIGNA CHOICE FUND AND OTHER CONSUMER DIRECTED ACCOUNT ADMINISTRATION SERVICES AND CHARGES		
	Product	**Charge**
	• Cigna Choice Fund Health Reimbursement Account (HRA) Administration	**$4.94/employee/month Non-COBRA Only 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. • 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 Members to provide coaching for those identified with gaps for high cholesterol, high blood pressure • Support of Participants identified through predictive modeling with certain preference sensitive care conditions by supplying impartial evidence based medical information, to empower Participants' to understand the potential benefits/ disadvantages of a specific course of action and make more informed care decisions. • Answering health and medical related questions • Counseling Participants on prevention and the benefits of compliance with prescribed medications and treatments	**For HRA OAP (All Plans) Included in Medical Access Fee**
AMOUNTS OWED TO CHLIC		
Amounts paid by CHLIC with its own funds on behalf of Employer or the Plan with respect to charges for which Employer or the Plan is obligated to pay under this Agreement including Plan Benefits, Bank Account Payments (including fix per person payments and pay-for-performance payments to Participating Providers), governmental taxes or assessments.		

	CIGNA PHARMACY BENEFIT MANAGEMENT SERVICES CHARGES AND RELATED PROVISIONS	

Definitions

- "Average Wholesale Price" or "AWP" is the Average Wholesale Price for a given pharmaceutical product in effect on the dispense date for the actual package size dispensed as published by Medi-Span or other alternative publication or benchmark reasonably designated by CHLIC.
- "Brand Drug Claim" is a claim for a pharmaceutical product that is adjudicated as a brand drug as indicated on the claim record generated by the claim processing system used by CHLIC. For application of discounts and dispensing fees, a "Brand Drug Claim" includes a claim for a generic drug within its exclusivity period or other period of limited competition, as CHLIC reasonably determines under its standard policies.
- "Generic Drug Claim" is a claim for a pharmaceutical product that is adjudicated as a generic drug as indicated on the claim record generated by the claim processing system used by CHLIC. For application of discounts and dispensing fees, a "Generic Drug Claim" excludes a claim for a generic drug within its exclusivity period or other period of limited competition, as CHLIC reasonably determines under its standard policies.
- "Mail Service Pharmacy" or "Cigna Tel-Drug" or "Cigna Home Delivery Pharmacy" is a pharmacy that is owned or operated by Connecticut General or an affiliated company(ies) (currently, Tel-Drug, Inc. and Tel-Drug of Pennsylvania, LLC), which dispenses drugs covered under the Plan's Pharmacy Benefit by mail, and is not a Retail Pharmacy.
- "Pharmacy Benefit" means the terms of the Plan that govern coverage and care/utilization management of drugs and related supplies dispensed to Members and charged to the Plan by the Mail Service Pharmacy or Retail Pharmacies through CHLIC's pharmacy claim processing system.
- "Rebates" or "Manufacturer Formulary Payments" means amounts that CHLIC collects under contracts with drug manufacturers that are based on utilization of certain of the manufacturers' brand drugs under the Plan's Pharmacy Benefit and the drug's status on the Cigna drug formulary.
- "Retail Pharmacy" is a pharmacy that is entitled to payment under the Plan for drugs it dispenses that are covered under the Plan's Pharmacy Benefit, and is not a Mail Service Pharmacy.
- "Specialty Drug Claim" is a claim for a pharmaceutical product that is reasonably determined by CHLIC to be a specialty drug in accordance with industry practice. Specialty drugs generally are (i) injected or infused and derived from living cells, or are oral non-protein compounds (e.g., oral chemotherapy drugs); (ii) target the underlying condition, which is usually one of a relatively rare, chronic and costly nature; and/or (iii) require restricted access and/or close monitoring.

PHARMACY ADMINISTRATION FEE
• Cigna Pharmacy Product Administration Fee: Included in Medical Administration Charge
CHARGES FOR DRUGS COVERED UNDER THE PLAN'S PHARMACY BENEFIT
Drugs Dispensed by Mail Service Pharmacy: CHLIC will charge Employer the following for claims covered under the Plan's Pharmacy Benefit and dispensed by the Mail Service Pharmacy, subject to the "Drug Charges – Additional Provisions" section:
Brand Drug Claims: AWP minus an average discount of 20%. **Generic Drug Claims:** The drug's charge on a CHLIC generic Maximum Allowable Charge schedule that generates an annual average aggregate discount across Generic Drug Claims dispensed at Cigna Home Delivery Pharmacy to CHLIC group-client book of business of AWP minus 74.4%. **Specialty Drug Claims**: The drug's charge discounted as shown in the Cigna Home Delivery Pharmacy Standard-Level Specialty Drug List, attached as Appendix A hereto. **Home Delivery Drug Claims:** An average dispensing fee of no more than $0.00
Drugs Dispensed by Retail Pharmacies: CHLIC will charge Employer the following for drugs covered under the Plan's Pharmacy Benefit and dispensed by a Retail Pharmacy to the Plan Members, subject to the "Drug Charges – Additional Provisions" section:
Retail Brand Drug Claims: The lesser of (i) AWP minus an average discount of 17.10%; or (ii) the Retail Pharmacy's usual and customary charge. **Retail Generic Drug Claims** (other than those to which the above brand discount applies): The lesser of: (i) the drug's charge on a CHLIC generic Maximum Allowable Charge schedule that generates an annual average aggregate discount across Generic Drug Claims dispensed at Retail Pharmacies to CHLIC group-client book of business of AWP minus 72% (Plan-specific results may vary based on drug mix); or (ii) the Retail Pharmacy's usual and customary charge. **Retail Specialty Brand Drug Claims:** The lesser of (i) AWP minus an annual average aggregate discount of 10.5%; or (ii) the Retail Pharmacy's usual and customary charge. **Retail Drug Claims:** An average dispensing fee of no more than $1.40, except in the case of usual and customary claims, for which no dispensing fee is charged.

DRUG CHARGES – ADDITIONAL PROVISIONS
• Cigna Home Delivery Pharmacy's discounts are applied to the manufacturer average wholesale price (AWP) for the dispensed size (or to the AWP for the manufacturer-packaged quantity closest to the dispensed size, if there is no AWP for the dispensed size).
• The amount paid to the Retail Pharmacy for Brand, Generic, or Specialty Drug Claims may or may not be equal to the amount charged to Employer, and CHLIC will absorb or retain any difference.
• An excess achieved in any Plan-specific discount floor or dispensing fee cap offered under this Agreement will be used to offset a shortfall in any other Plan-specific discount floor or dispensing fee cap offered under this Agreement.
• Industry Changes to or Replacement of Average Wholesale Price (AWP). Notwithstanding any other provision in this Agreement, including in this Exhibit, in the event of any major change in market conditions affecting the pharmaceutical or pharmacy benefit management market, including, for example, any change in the markup, methodologies, processes or algorithms underlying the published AWP(s), CHLIC may adjust any or all of the charges, rates, discounts, guarantees and/or fees in connection with CHLIC's administration of the Plan's Pharmacy Benefit hereunder, including any that are based on AWP, as it reasonably deems necessary to preserve the economic value or benefit of this Agreement as it existed immediately prior to such change. Additionally, and notwithstanding any other provision in this Agreement, including in this Exhibit, CHLIC may replace AWP as its pharmaceutical pricing benchmark with an alternative benchmark and/or may replace Medi-Span, or other such publication as its source for the AWP or alternative benchmark with a different pricing source, provided that CHLIC adjusts any or all such AWP-Based Charges or such alternative benchmark-based charges as it reasonably deems necessary to preserve the economic value or benefit of this Agreement as it existed immediately prior to such replacement or immediately prior to the event(s) giving rise to such replacement, as the case may be.

DRUG MANUFACTURER-PAYMENT SHARING
Subject to the caveats below, CHLIC will remit to Employer the following portion of Rebates that CHLIC collects with respect to utilization under the Plan's Pharmacy Benefit: $26.27 per Retail Pharmacy Brand Drug Claim and $128.01 per Mail Service Pharmacy Brand Drug Claim.
Caveats: (1) Upon termination of this Agreement, CHLIC may apply Rebates otherwise payable to offset Bank Account or other deficits of charges identified in this Agreement. (2) Should Employer terminate this Agreement before completion of the then-current Plan Year, no Rebates shall be due with respect to that Plan Year as Rebates are based on completion of an entire Plan Year. (3) All applicable caveats communicated in writing by CHLIC in connection with its proposal made in connection with this Agreement are hereby incorporated by reference. (4) For percentage-based sharing arrangements, payout amount may differ slightly from the stated percentage when payout occurs before manufacturers' final reconciliations and payments are made to CHLIC. (5) Rebates are not paid out on Run-Out Claims or on claims for drugs covered under the federal 340B drug pricing program. (6) CHLIC or its agent contracts with drug manufacturers on CHLIC's own behalf, and not as agent of the Employer or the Plan. Timing of Rebate Pay-Out: Remittance will be provided within ninety (90) days after the close of each applicable calendar year for the portion of such calendar year that coincides with the Plan Year.
AUDIT RIGHTS RELATED TO MANUFACTURER PAYMENTS
Employer's third party auditor may audit records directly related to CHLIC's performance of its obligations hereunder regarding sharing of manufacturer formulary payments (a/k/a "rebates") once in each twelve-month period upon the following conditions: Employer shall provide at least forty-five (45) days written notice to CHLIC; the auditor (including its individual auditors conducting the audit) shall be agreeable to Employer and CHLIC; a mutually agreed upon non-disclosure/non-use contract shall be executed by Employer, the auditor and CHLIC; the records to be audited shall be no more than two years old as of the date of the audit; the scope of records to be audited shall be as mutually agreed upon by Employer's third party auditor and CHLIC as those which are necessary to determine compliance with the rebate-sharing obligations under this Agreement; the audit shall be conducted at a mutually acceptable time during regular business hours at CHLIC's office where such records are located; records shall not be removed or photocopied without CHLIC's express written consent; the auditor shall provide its audit report to CHLIC and Employer at the same time; and the auditor may disclose the aggregate amount of manufacturer formulary payments due Employer but no other details of CHLIC's manufacturer contracts of which the auditor is apprised, if any.

FEES FOR PROCESSING RUN-OUT CLAIMS		
OAP, HRA OAP and DPPO	Run-Out Period of twelve (12) months	**No Additional Cost**
Pharmacy	Run-Out Period of three (3) months for all pharmacy claims	**No Additional Cost**
SUBROGATION		
	Subrogation/Conditional Claim Payment. Identification, investigation and recovery of claim payments involving other party liability or where another entity is responsible for payment (including by way of example but not by limitation automobile insurance, homeowner insurance, commercial property insurance, worker's compensation). (This service is only provided with respect to Medical coverage).	**5% of recovery plus litigation costs if counsel is retained and an appearance is filed on behalf of CHLIC or Employer in any litigation, or a lawsuit is filed on their behalf;** **29% of recovery if no counsel is retained and in all other instances, including cases where state law requires that employee benefit plans be named as party defendants or involuntary plaintiffs.**

CHLIC COST CONTAINMENT FEES

CHLIC, a Cigna company, administers the following programs to contain costs with respect to charges for health care service/supplies that are covered by the Plan. In administering these programs, CHLIC contracts with vendors to perform program related services. Specific vendor fees are available upon request. CHLIC's charge for administering these programs is the percentage (indicated below) of either (1) the "net savings" (i.e. the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings, less the applicable vendor fee which generally ranges from 7-11% of the program savings) or (2) the "gross savings" (i.e. the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings; CHLIC pays the applicable vendor fee) or (3) the "recovery" (i.e. the amount recovered) as applicable.

For charges for covered services received from a non-Participating Provider (including emergency/urgent care services that are covered at the in-network benefit level), CHLIC may apply discounts available under agreements with third parties or through negotiation of the billed charges. These programs are identified below as the Network Savings Program, Supplemental Network & Medical Bill Review (pre-payment). CHLIC charges the percentage shown for administering these programs. Applying these discounts may result in higher payments than if the maximum reimbursable charge is applied. Whereas application of the maximum reimbursable charge may result in the patient being balance billed for the entire unreimbursed amount, applying these discounts avoids balance billing and substantially reduces the patient's out-of pocket cost.

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

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

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

a. the amount of provider's billed charge not exceeding the greater of a CHLIC determined percentage of the Medicare allowable amount (the 80th percentile of the reasonable and customary charge if there is no Medicare allowable charge) or the amount required by state or federal, law (in the case of emergency room services) for charges subject to CHLIC's benefit enhancement policy (patient may be balance billed by the provider if the provider's charge exceeds such amount), or

b. the provider's billed charge.

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

MEDICAL AND PHARMACY COST CONTAINMENT		
1.	Network Savings Program	**29% of net savings**
2.	Supplemental Network	**29% of net savings**
3.	Medical Bill Review – (Pre-payment Cost Containment for Non-contracted claims):	
	Inpatient Hospital Bill Review	

	• Line Item Analysis	**Lesser of 5% of hospital bill or the savings achieved**
	• Professional Fee Negotiation	**29% of net savings**
	Outpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
	Physician/Professional Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
4.	Medical Bill Review – (Pre or Post-payment Cost Containment for Non-contracted and Contracted claims):	
	• Bill Audit	**29% of the savings/recovery achieved plus hospital fees or expenses passed through**
	Diagnosis Related Grouping (DRG) Validation/Audits and Recovery. An overpayment audit and recovery program in which CHLIC or its vendors review paid claim data to identify overpayments based on inaccurate DRG coding.	**29% of recovery plus any fees or expenses passed through by the hospital or regulatory agency**
	Inpatient Admission Retrospective Review	**29% of recovery**
	Medical Implant Device Audits	**29% of recovery**
5.	COB Vendor Recoveries [Exclusive of pharmacy programs where claims are adjudicated at time prescription is received.]	**29% of recovery**
6.	Secondary Vendor Recovery Program	**29% of recovery**
7.	Provider Credit Balance Recovery Program	**29% of recovery**
8.	High Cost Specialty Pharmaceutical Audits	**29% of recovery**
9.	Pharmacy Vendor Recoveries	**30% of recovery**
10.	Class Action Recoveries	**35% of recovery**

DENTAL COST CONTAINMENT		
	Dental Cost Containment	**25% of gross savings**
CARE MANAGEMENT/COST CONTAINMENT PROGRAM FEES		
	CHLIC arranges for third parties to provide care management services to: (i) contain the cost of specified health care services/items overall with respect to all plans insured and/or administered by CHLIC, and/or (ii) improve adherence to evidence based guidelines designed to promote patient safety and efficient patient care.	**Specific vendor fees and care management program services are available upon request.**
ELIGIBILITY OVERPAYMENT RECOVERY FEES		
	Eligibility Overpayment Recovery Vendor Services. Identification and recovery of funds in situations where the overpayment is due to the late receipt of Member termination information. (This service is only provided with respect to Medical coverage).	**29% of recovery**
EXTERNAL REVIEW AND CONSULTATIVE REVIEW FEES		
	When a Member elects an External Review (as that term is defined in ERISA) of a benefit determination by an independent third party, the cost of a specific third party review is dependent on the nature and complexity of the issue on appeal. In highly complex, non-routine cases or cases related to new technology or experimental-investigational treatment, as part of the internal appeal process a panel of reviewers may be necessary. Third party review charges will be commensurate with the number of reviewers (usually only one is used), as well as their level of expertise and time required to complete the review.	**$500-$4,000 Review**
STRATEGIC ALLIANCES		
	CHLIC contracts directly or indirectly with other managed care entities and third party network vendors for access to their provider networks and discounts. These third parties charge either a network access fee, which is included in CHLIC's monthly charges, or a percentage of the savings realized on a claim by claim basis as a result of the application of their discounts. Charges based on percentage of savings are paid from the Bank Account. Additional details regarding specific charges will be provided upon request.	**All Medical Products**

	OTHER VENDORS AND HEALTH CARE SERVICES PROVIDERS	
	Fixed per person per period and fee-for-service charges for various vendors and other providers/arrangers of health care services and/or supplies will be paid as claims for Plan Benefits. In addition, performance-based payments to Participating Providers will be charged to the Bank Account. Such payments will be at the payment rates then in effect, which may be amended from time to time. Additional details regarding charges and the identity of the vendor or provider of health care services will be made available upon request.	**All Products**
	NOTICE REGARDING PAYMENTS FROM THIRD PARTIES	
	Unless indicated otherwise in the Schedule of Financial Charges, CHLIC retains all payments it may receive from manufacturers of pharmaceutical products covered under the Plan. Information on the amount of such payments with respect to the Plan will be provided upon request.	**All Pharmacy Products**
	From time to time, CHLIC, directly or through its affiliates, arranges with third party parties (e.g., service vendors, provider network managers) to provide various services (e.g., cost-containment initiatives) in connection with the Plan. CHLIC and its affiliates may receive payments from such third parties to help defray CHLIC's expenses associated with the implementation and/or ongoing administration of these arrangements. CHLIC may also receive compensation from third-party vendors that Employer may retain based upon a referral from CHLIC.	**All Products**
	COMPLIANCE ASSISTANCE	
	CHLIC shall provide the following services to assist Employer in meeting its compliance obligations under section 2715 of the Public Health Service Act as added by the Patient Protection and Affordable Care Act and applicable regulations with respect to the provision of the Summary of Benefits and Coverage ("SBC), translation notice and glossary. Applicable to all medical plans including HRA and FSA which are considered "group health plans" subject to the SBC requirements.	
1.	Preparation of SBC, translation notice. CHLIC will not be responsible for any changes that Employer makes to the SBC.	**No charge**
2.	Provide SBC, translation notices prepared by CHLIC to Employer electronically as well as any updates or material modifications.	**No charge**
3.	Include in SBC a summary of benefits administered by carve-out vendor if Employer or carve-out vendor provides CHLIC with necessary carve-out benefit information at least twelve (12) weeks prior to the date the SBCs are to be delivered to Employer.	**$500 for each benefit option under the Plan for which carve-out vendor benefits are included in SBC**

ADDITIONAL SERVICES		
Service	**Description**	**Charge**
Clinical Program	**Cigna TheraCare® Program** – a targeted condition drug therapy management program that targets individuals using specialty medications for certain chronic conditions and helps them better understand their condition, medication side effects and importance of adherence.	**Included at No Additional Cost**
Your Health First	A proactive health education and improvement program for Members with a chronic condition. The program involves services that span across the Member's health needs. Behavioral coaching principles and evidence based medicine guidelines are utilized to optimize self-management skills and foster sustained health improvements. The program targets a chronic population at high risk for near term and future high cost medical expenses. Members are identified as having a chronic condition through a variety of sources which may include: claims data, referrals, and self-identification. A variety of resources is provided to those with a chronic condition, including access to online tools, personalized support, and targeted materials. The program includes the following components for those with a chronic condition: • Chronic condition-specific coaching • Pre- and post-discharge calls • Lifestyle management coaching: stress, weight management and tobacco cessation • Treatment decision support and coaching In order to continuously assess the effectiveness of the program and/or test new ideas to further engage Members around their health, a small sample of Members may be placed in a comparison group which for a defined period of time receives alternative services or is suppressed from receiving proactive outreach, such as engagement letters and/or calls. This could affect a few Members targeted for outreach during this limited time period.	**For OAP and HRA OAP Products: Included in Medical Access Fee**

Claim Litigation	Claim Litigation Services	**$3,500 Flat Annual Amount: Included in Medical Administration Charge**
Claim and Appeals	CHLIC will administer an optional second level of claim appeals	**$0.94/employee/year Included in Medical Administration Charge**
Internet-Based Enrollment and Eligibility Management System	CHLIC, either directly or through its affiliate, Choicelinx®, will grant to Employer and Participants a nontransferable limited license to access Benefits Insight, CHLIC's Internet-Based Enrollment and Eligibility Management System for online enrollment and selection of benefits. Products and services are outlined in the Statement of Services provided to the Employer by Choicelinx®. More specific information about the products, services, charges, grant of license and applicable restrictions are available upon request.	**Included in Medical Administration Charge**

Exhibit A - Plan Booklet

A "Plan Booklet" that describes the Plan Benefits and Members' rights and responsibilities under the Plan will be provided by Employer to CHLIC for its use in administering the Plan including denials and appeals of denials of claims for Plan Benefits. If Employer has not provided CHLIC with a copy of its finalized Plan Booklet by the time this Agreement is effective, CHLIC will administer the Plan in accordance with the Plan Benefits described in the Plan Booklet draft provided by CHLIC to Employer and Section 2 of this Agreement. CHLIC will continue to administer the Plan in this manner until CHLIC receives the finalized Plan Booklet and follows CHLIC's preparation and review process. After that time CHLIC will administer the Plan in accordance with Plan Benefits described in the finalized Plan Booklet and Section 2 of this Agreement.

Exhibit B – Services

BANKING AND ADMINISTRATION		
Products excluding Health Savings Account		
1.	Furnishing CHLIC's standard Bank Account activity data reports to Employer as and when agreed upon. CHLIC's administration of the Plan does not include performing obligations, if any, under state escheat or unclaimed property laws. It is Employer's responsibility to determine the extent to which these laws may apply to the Plan and to comply with such laws.	**All Products**
2.	Report to Employer the claim payment information required in connection with Section 6041of the Internal Revenue Code.	**All Products**
3.	If Employer has elected, pursuant to section 63 of the New York Health Care Reform Act of 1996 (section 2807-t of the Public Health Law) ("the Act"), to pay the assessment on covered lives set forth in section 63 and has consented to the conditions set forth in section 63, CHLIC shall file such forms and pay such surcharge and assessment on covered lives on behalf of Employer through the Bank Account to the extent set forth in section 63. Such obligation shall end immediately upon Employer's failure to provide any information required by CHLIC to fulfill this obligation, the failure to comply with any requirement imposed upon Employer pursuant to the Act or the failure of Employer to properly fund the Bank Account. In addition, where permitted and agreed to by CHLIC, CHLIC will file applicable forms and pay on behalf of Employer and/or the Plan any assessment, surcharge, tax or other similar charge which is required to be made by Employer and/or the Plan based on covered lives and/or paid claims or otherwise in accordance with and as required by other applicable state and/or federal laws and regulations and the Bank Account will be charged for any such payments made by CHLIC.	**All Products**
CLAIM ADMINISTRATION		
Products excluding Health Savings Account		
1.	Calculate benefits, check and/or electronic payments disbursed from Employer's Bank Account. Bank Account payments will appear in Employer's standard Bank Account activity data reports.	**All Products**
2.	Prepare and make available CHLIC's standard claim forms.	**All Products**
3.	Investigate claims, as necessary, by CHLIC's Special Investigations Unit.	**All Products**
4.	Discuss claims, when appropriate, with providers of health services.	**All Products**
5.	Perform, based on CHLIC's book of business internal audits of plan benefit payments on a random sample basis.	**All Products**
6.	Claim control procedures reported annually in Statement on Standards for Attestation Engagements (SSAE) No. 16 Report (SAS70 successor report).	**All Products**

7.	Respond to Insurance Department complaints.	**All Products**
8.	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Products**
9.	Member Explanation of Benefit ("EOB") statements including, when applicable, notice of denied claims, denial reason(s) and appeal rights.	**All Products (excluding Pharmacy)**
10.	Verify enrollment and eligibility using Member information submitted by Employer and/or its authorized agent.	**All Products**
	Medical Only	
1.	CHLIC's standard enrollment forms are prepared and delivered to Employer for distribution to individuals eligible to enroll in the Plan.	**All Medical Products**
2.	CHLIC's standard ID card with toll-free telephone number are prepared and mailed directly to Members.	**All Medical Products**
3.	Administration of subrogation/conditional Claim Payment (terms described in Exhibit E).	**All Medical Products**
	Dental Only	
1.	CHLIC's standard enrollment forms are prepared and delivered to Employer for distribution to individuals eligible to enroll in the Plan.	**All Dental Products**
2.	CHLIC's generic ID cards are prepared and bulk shipped to the employer's address to distribute to their employees.	**All Dental Products**
3.	Standard Dental predetermination of benefits for dental procedures on a voluntary basis.	**All Dental Products**
4.	When elected, the Cigna Oral Health Integration Program® (OHIP) includes the provision of administrative services necessary to provide eligible Members with certain health conditions enhanced dental benefits. The program covers the following conditions: Maternity, Diabetes, Cardiovascular Programs, cerebrovascular disease (stroke), chronic kidney disease, organ transplants and head/neck cancer radiation, and is aimed at improving overall health by encouraging Members to obtain needed dental treatment by providing enhanced benefits. As appropriate, OHIP may be expanded to include new procedures, conditions and programs in the future.	**All Dental Products**
	Pharmacy Only	
1.	CHLIC's standard ID cards with toll-free telephone number are prepared and mailed directly to Members.	**All Pharmacy Products**
2.	Pharmacy claims are adjudicated typically on-line at time of service without access to information on other coverage, and therefore coordination of benefits (COB) for pharmacy claims does not occur. Claims for Plan Benefits will be paid regardless of coverage under another plan.	**All Pharmacy Products**
3.	CHLIC's standard drug utilization review services.	**All Pharmacy Products**
4.	CHLIC may receive and retain payments under contracts with drug manufacturers with respect to utilization covered under the Employer's medical benefit for the manufacturer's specialty drugs, which are drugs that typically are injected or infused and derived from living cells; target an underlying rare, chronic or costly condition; and/or require restricted access and/or close monitoring. If CHLIC enters into any such contracts, it does so on its own behalf, and not as agent of the Employer or the Plan.	**All Pharmacy Products**

Health Reimbursement Account (HRA), Healthy Awards (HA) and Healthy Future (HF) Only		
1.	Providing reimbursement request forms to Employer.	**HRA Product**
2.	Employer will make available specific funds to eligible employees enrolled in the HRA, HA and/or HF as applicable (**"Participating Members"**). At the end of each reimbursement period of the Plan Year, CHLIC shall issue payments to Participating Members (or their medical provider, if appropriate) to the extent of the maximum amount of payment allowed by Employer reduced by prior reimbursements for the same period of coverage, for the amount that is determined by it to be proper under the Plan.	**HRA Product**
3.	Allowable expenses for reimbursement under a HRA, HA and/or HF, as applicable, include all allowable health-related expenses, pursuant to I.R.C. Section 213 except where payment for any such products is prohibited. The Employer can further limit the allowable expenses as agreed to by the Employer during implementation.	**HRA Product**
4.	Account balances for Participating Members active until the end of the Plan Year will remain open after conclusion of the Plan Year for a period of one year, (the "**Run Out Period**"), so that such Participating Members can submit any remaining expenses incurred during the Plan Year.	**HRA Product**
5.	A Participating Member's request to terminate his/her enrollment in the HRA, HA, and/or HF, as applicable, will continue to be processed for one year following termination for any expenses incurred prior to his/her Participating Membership termination date up to the originally selected goal amount, minus prior reimbursements.	**HRA Product**
6.	For reimbursement payments that are made as a result of automatic claim forwarding ("AutoPay") of medical claims from a medical plan administered by CHLIC or Direct Submit Request For Reimbursement, an explanation of payment will be mailed to the Participating Member at their home address. An explanation of payment is not issued for payments that are issued to a pharmacy at the point of service as a result of AutoPay from the employee's pharmacy Plan or for any Debit Card transactions.	**HRA Product**
7.	Providing information on account balances and submitted claims to Participating Members calling the number on the ID card. In addition, Participating Members will have access to account information via Internet.	**HRA Product**
8.	When automatic claim forwarding ("AutoPay") is turned on, medical claims processed but unpaid by CHLIC will be automatically submitted for reimbursement from the HRA and/or HA Participating Member's HRA and/or HA account. Such "rollover" claims will be processed without additional submissions by the Participating Member.	**HRA Product**
9.	When CHLIC takes over HRA, HA and/or HF administration mid-Plan Year, CHLIC will provide administrative services from the date the Plan information is received.	**HRA Product**

10.	For employee enrolled in an HRA, HA and/or HF Plan with a debit card, a debit card will be issued to each HRA, HA and/or HF participating employee and spouse (if spouse is enrolled in the Plan). A debit card will also be issued upon employee request to other eligible dependents. (Employees enrolled in both a health care FSA Plan with a debit card and a Health Reimbursement Account Plan with a debit card will only receive one debit card covering both Plans.) The card is pre-loaded with the Participating Member's annual HRA, HA and/or HF goal amount for the Plan Year. Plan Year HRA, HA and/or HF funds are available using the debit card for transactions actually processed during the Plan Year period. The card does not access funds from a prior Plan period the employee re-enrolls in the HRA, HA and/or HF for the subsequent period and has remaining HRA, HA and/or HF funds that carry over to the new period. If an employee terminates their HRA, HA and/or HF Plan or does not re-enroll in the HRA, HA and/or HF the debit card will be de-activated and will not be available for use after the last day of the employee's HRA, HA and/or HF enrollment. The card is used by the HRA, HA and/or HF Participating Member to access available HRA, HA and/or HF funds based upon the submitted goal amount plus any added incentive reward dollars (if applicable) less amount paid Plan Year to date from the fund. Since debits made with the card are not submitted by the card vendor to CHLIC in real-time but only on a daily basis, Employer agrees to fund all debits made by the Participating Member through the time through the daily feed from the card vendor that indicates the Participating Member's account is exhausted. The card is restricted to specific merchant types that are considered health care related based on service category elections. Although the card is limited to these types of merchants, the card does not limit specific items within these merchants. When the debit card is used, funds are automatically deducted from the HRA, HA and or HF. HRA, HA and/or HF Participating Members may be required to submit receipts to CHLIC to substantiate debit card expenditures. If appropriate substantiation is not received, the debit card will be suspended and no longer available for use.	**HRA Product**
11.	Pharmacy claims: Eligible pharmacy expenses, under the HRA and/or HA that are processed but unpaid by CHLIC may be automatically submitted ("rolled over") to the Reimbursement Accounts Claim Office for reimbursement from the Participating Member's HRA, HA and/or HF account if the AutoPay option is enabled. Such rollover claims will be processed without additional submissions by the Participating Member. When pharmacy is covered and Cigna Pharmacy is the pharmacy vendor, the HRA and/or HA will automatically pay the pharmacy through the HRA and/or HA at the point of sale for all Participating Member obligations under the pharmacy Plan including deductibles, copays, and/or coinsurance obligations. A Participating Member will not receive an Explanation of Benefits for these payments.	**HRA Product**

	PLAN BOOKLET	
	Products excluding Health Savings Account	
	Prepare and make accessible Member benefit booklet drafts to Employer.	**All Products**
	UNDERWRITING SERVICES	
1.	5500 Schedule C reporting.	**All Products**
2.	5500 Schedule A or Annual Reconciliation Disclosure reporting (when applicable)	**All Products**
3.	CHLIC's standard Underwriting services: a) benefit design analysis-b) projected cost analysis.	**All Products**
	HIPAA INDIVIDUAL RIGHTS	
	Products excluding Health Savings Account	
	Handling of requests from Members for access to, amendment and accounting of protected health information, and requests for restrictions and alternative communications as required under federal HIPAA law and regulations, as set out in this Agreement and its Exhibits.	**All Products**
	COST CONTAINMENT	
1.	Maximum reimbursable charge determinations of non-Participating Provider charges for covered services.	**All Medical Products (with out-of-network benefits)**
2.	CHLIC's standard cost containment controls: Application of non-duplication and coordination of benefits rules and coordination with Medicare.	**All Medical Products**
3.	Delivery of information, as necessary, regarding standard application of non-duplication or coordination of benefits.	**All Medical and Dental Products**
4.	Review of medical bills in accordance with CHLIC's then current Medical Bill Review program.	**All Medical Products**
5.	Dental Cost Containment, a network of additional participating PPO providers that provide discounts for which CHLIC retains a portion of the savings generated.	**All Dental Products**
6.	Network Savings Program, a national vendor network that provides discounted rates when a Member accesses care through a Network Savings Program contracted provider.	**All Medical Products**
7.	Annual reporting of CHLIC's standard cost containment results upon Employer's request.	**All Medical and Dental Products**
8.	Pharmacy Vendor Recoveries.	**All Pharmacy Products**

	CUSTOMER REPORTING	
1.	Summary reports of medical, dental and pharmacy cost and utilization experience are available through Cigna's web site, CignaAccess.com.	**All Medical, Dental and Pharmacy Products**
2.	CHLIC's standard pharmacy utilization reports.	**Pharmacy Product Only**
3.	Claim Reporting: CHLIC will provide standard banking and financial report information based upon paid claim data. CHLIC will not provide information on incurred-but-not reported claims, projected claims, pre-certifications of coverage, case management information or information on a Member's prognosis or course of treatment. Stop Loss Reporting is an optional service provided at an additional fee to Employers who have stop loss through another entity other than CHLIC. CHLIC will provide its standard reporting only after the stop loss carrier and Employer have executed CHLIC's standard Hold Harmless/Confidentiality Agreement.	**All Medical Products**
4.	CHLIC's standard Individual Summary Statements for applicable participating Members.	**HRA Product**
5.	CHLIC's standard Health Reimbursement Account, Healthy Awards and/or Healthy Future activity report for Employer.	**HRA Product**
	COMPLIANCE	
	Employer directs CHLIC in administering the Health Care Flexible Spending Account, Healthy Awards, Healthy Futures and/or Health Reimbursement Account benefit to comply with COBRA as follows:	
1.	The HRA, HA and/or HF of each HRA, HA and/or HF Participating Member who experiences a qualifying event and elects continuation of account coverage in accordance with COBRA will be maintained similar to the maintenance of an active employee. HF Participating members that have not met their vesting requirements determined by the plan are not required to be offered COBRA for the HF.	**HRA Product**
	MEMBER EXTERNAL REVIEW PROGRAM	
	CHLIC contracts with three (3) independent review organizations that meet the Patient Protection and Affordable Care Act (PPACA) external review requirements. Members may appeal eligible claims to an external independent review organization which is selected by CHLIC on a random basis. If Employer has chosen not to participate in this program, the Employer may be responsible for making other arrangements to meet the Patient Protection and Affordable Care Act (PPACA) external review requirements.	**All Medical Products**

	MEDICAL MANAGEMENT SERVICES	
	CHLIC provides integrated medical management that includes (depending upon the terms of the Plan) the following core services.	
1.	Pre-Admission Certification and Continued Stay Review (PAC/CSR) services to certify coverage of acute and sub-acute inpatient admissions/stays or provides guidance to appropriate alternative settings. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products**
2.	Case Management and Retrospective Review of Inpatient Care, a service designed to provide assistance to a Member who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support.	**All Medical Products**
3.	Assisting providers with resources and tools to enable them to develop long term treatment plans in the management of chronic or catastrophic cases.	**All Medical Products**
4.	The Cigna HealthCare Healthy Babies® Program is a one-time educational mailing which provides Participants with prenatal care education and resources to help them better manage their pregnancy. Other benefits of this program include the 24-Hour Health Information Line℠ and pregnancy information on myCigna.com.	**All Medical Products**
5.	HealthCare Cost and Quality tools on myCigna.com	**All Medical Products**
6.	A panel of physicians and other clinicians to assess the safety and effectiveness of new and emerging medical technologies. The panel meets monthly to review and update coverage policies.	**All Medical Products**
7.	The 24-Hour Health Information Line℠ is a service that provides 24 hour toll free access to nurses, who provide answers to healthcare questions, recommends appropriate settings for care and assists Participants in locating physicians. It also includes access to an extensive audio library on a wide range of medical topics.	**All Medical Products**
8.	Cigna LifeSOURCE Transplant Network® contracts with over seven hundred (700) transplant programs at more than one-hundred fifty (150) independent transplant facilities and provides access to solid organ and bone marrow/stem cell transplantation while improving cost containment and reducing financial risk.	**All Medical Products**
9.	A health education program that delivers mailings to Members with certain conditions.	**All Medical Products Except Comprehensive and Indemnity**
10.	If behavioral health services are provided/arranged by Cigna Behavioral Health (CBH), CBH provides utilization review and case management for both inpatient and outpatient, in-network behavioral health services.	**For OAP and HRA OAP Products Only (Non-CA/NC Members)**
11.	Implementing clinical quality measurements, managing data, tracking and validating performance and initiating continuous quality improvement.	**All Medical Products Except Comprehensive and Indemnity**

12.	Transition of care services to allow Members with defined conditions to continue treatment with non-Participating Providers after enrollment for continued uninterrupted care for a limited time.	**All Medical Products Except Comprehensive and Indemnity**
13.	Focused utilization management of outpatient procedures and identification of appropriate alternatives. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products with PHS Plus**
	NETWORK MANAGEMENT SERVICES	
	CHLIC, and/or its affiliates or contracted vendors shall:	
1.	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, fixed per person per period, per diem charges, incentive bonuses, case rates, withholds etc.). The amount and type of negotiated reimbursement may vary depending upon the type of plan. For example, a hospital may accept less for patients enrolled in certain types of plans than others;	**All Medical and Pharmacy Products**
2.	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, fixed per person per period, per diem charges, incentive bonuses, case rates, withholds etc.);	**All Dental Products**
3.	Credential and re-credential Participating Providers in accordance with CHLIC's credentialing requirements and ensure that third-party network vendors credential/re-credential Participating Providers in accordance with CHLIC's requirements;	**All Medical, Dental and Pharmacy Products**
4.	Monitor Participating Provider compliance with protocols and procedures for quality, Member satisfaction, and grievance resolution;	**All Medical, Dental and Pharmacy Products**
5.	Facilitate the identification of Participating Providers by Members; and	**All Medical, Dental and Pharmacy Products**
6.	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Medical, Dental and Pharmacy Products**

	BEHAVIORAL HEALTH	
	CHLIC has contracted with an affiliate, Cigna Behavioral Health ("CBH"), to provide or arrange for the provision of managed in-network behavioral health services, CBH is a Participating Provider, and is reimbursed primarily on a monthly fixed fee basis. This fixed fee for CBH services will be paid as claims and will appear in Employer's monthly reporting and on financial documents. Such payments will be at the relevant monthly rates then in effect. The monthly rates paid to CBH vary depending on geographic location of Members and on benefit design, and may be subject to change. The rates will be made available upon request. The fixed fee also includes lifestyle management programs, a cognitive behavioral modification program, a Complex Psychiatric Case Management program, and a Narcotics Therapy Management program. Behavioral claims from a client specific network are not included in the behavioral monthly fixed fee and will be paid from the Bank Account. In some states, payment for behavioral health services must be paid on a fee-for-service basis. In these states, fee-for-service payments for behavioral health services and the CBH administrative fee (including the lifestyle management programs, a cognitive behavioral modification program a Complex Psychiatric Case Management program and a Narcotics Therapy Management program) will be paid from the Bank Account as claims and will appear in Employer's monthly reporting.	**These services are included in the following products: OAP and HRA OAP**
	CIGNA STAFF MODEL HEALTHPLAN SERVICES	
	The Cigna HealthCare of Arizona, Inc. staff model ("Cigna Medical Group") is a Participating Provider located in metropolitan Phoenix, Arizona. Plan Members may at some time receive treatment from a Cigna Medical Group ("CMG") facility or provider even if they do not reside in Arizona (as when traveling). Members utilizing the IPA network will access certain specialty and/or ancillary services (including laboratory and urgent care services) through the CMG system. Lab services are not provided by CMG for Members in PPO or EPO plans. Except as provided below, for services provided to Members, CMG is paid at the rates in effect at the time of service (as may be revised from time to time). Representative rates for routinely performed services are attached. A complete copy of the rates is available on request under a mutually agreed nondisclosure agreement (NDA). If the Plan requires Members to select a primary care physician (PCP), Phoenix area Members who do not select a PCP during open enrollment are assigned to a CMG PCP. CMG is paid for PCP-required Plans at the rates in effect at the time of service. Primary care services rendered to Members in Open Access or LocalPlus Plans that do not provide for PCP assignment are paid at the rates then in effect, as described above.	**All Medical Products**

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

EFFECTIVE AUGUST 1, 2014

(Applicable to all Open Access Plus Products)

Department	CPT Code	Description	OAP Rate
All Departments	99213	OFFICE VISIT,EST EXP PROB FOC	$65.80
Adult Medicine	99396	WELL EXAM, EST, 40-64 YEARS	$102.94
Pediatrics	99392	WELL EXAM, EST, 1-4 YEARS	$85.77
Gastroenterology	45378	COLONOSCOPY - Professional Fee only, at a facility	$257.75
Neurology	64615	CHEMODENERVATION OF MUSCLE MIGRAINE	$157.18
Ophthalmology	66984	REMOVE CATARACT, INSERT LEN- Professional Fee only, at a facility	$700.01
Podiatry	11721	DEBRIDEMENT NAIL SIX OR MORE	$39.95
Radiology	71020	CHEST X-RAY, PA & LAT	$30.38
Radiology	G0202 + 77052	SCREENING MAMMOGRAPHY DIGITAL	$141.02
Urology	52000	CYSTOSCOPY	$253.87
General Surgery	47562	LAPAROSCOPY;CHOLECYSTECTOMY- Professional Fee only, at a facility	$837.79
Optometry	92014	EYE EXAM & TREATMENT	$109.35
Lab	80053	COMPREHENSIVE METABOLIC PANEL	$14.87
Lab	80061	LIPID PANEL	$18.85
ASC (Ambulatory surgical center) / Endoscopy Suite	Grouper 2		$469.00
ASC (Ambulatory surgical center) / Endoscopy Suite	Grouper 8		$1,104.00

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

The Urgent Care case rate excluding radiology and laboratory services is $115.

CMG pharmacy rates (30-day supply):
Brand Name: AWP – 10.56% + $2.75 dispensing fee
Generic: AWP – 35% + $2.75 dispensing fee

Exhibit C – Claim Audit Agreement (Sample)

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

B. WHEREAS, _____("Auditor") has been retained by Employer for the purpose of performing an audit ("Audit") of claims administered by CHLIC;

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

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

1. Audit Specifications

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

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

2. Review of Specifications

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

3. Access to Information

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

4. Audit Report

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

5. Comment on Audit Report

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

6. Confidentiality

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

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

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

7. Restricted Use of the Audit Information

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

8. Termination

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

Cigna Health and Life Insurance Company

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date: _____

Employer: _____

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date: _____

Auditor: _____

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date: _____

Exhibit D – Privacy Addendum

("Business Associate Agreement")

I. GENERAL PROVISIONS

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

Section 2. Amendment to Comply with Law. CHLIC, on behalf of itself and its affiliates and subsidiaries that perform services under the Agreement (collectively referred to as **"CHLIC"**), Employer (also referred to as "**Plan Sponsor**"), and the group health plan that is the subject of the Agreement (also referred to as the **"Plan**") agree to amend this Addendum to the extent necessary to allow either the Plan or CHLIC to comply with applicable laws and regulations including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160 to 164) ("**HIPAA Privacy and Security Rules**").

Section 3. Relationship of Parties. The parties intend that CHLIC is an independent contractor and not an agent of the Plan.

II. PERMITTED USES AND DISCLOSURES BY CHLIC

Section 1. Uses and Disclosures Generally. Except as otherwise provided in this Addendum, CHLIC may use or disclose PHI to perform functions, activities or services for, or on behalf of, the Plan as specified in the Agreement, provided that such use or disclosure would not violate the HIPAA Privacy & Security Rules if done by the Plan. CHLIC shall not further use or disclose PHI other than as permitted or required by this Addendum, or as required by law.

Section 2. To Carry Out Plan Obligations. To the extent CHLIC is to carry out one or more of the Plan's obligations under Subpart E of 45 C.F.R. Part 164, CHLIC agrees to comply with the requirements of Subpart E that apply to the Plan in the performance of such obligations.

Section 3. Management and Administration.

(A) CHLIC may use PHI for the proper management and administration of CHLIC or to carry out the legal responsibilities of CHLIC.

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

breached.

(C) CHLIC may use or disclose PHI to provide Data Aggregation services relating to the Health Care Operations of the Plan, or to de-identify PHI. Once information is de-identified, this Addendum shall not apply.

Section 4. Required or Permitted By Law. CHLIC may use or disclose PHI as required or permitted by law.

III. OTHER OBLIGATIONS AND ACTIVITIES OF CHLIC

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

Section 2. Limited Data Set or Minimum Necessary Standard and Determination. CHLIC shall, to the extent practicable, limit its use, disclosure or request of Individuals' PHI to the minimum necessary amount of Individuals' PHI to accomplish the intended purpose of such use, disclosure or request and to perform its obligations under the underlying Agreement and this Addendum. CHLIC shall determine what constitutes the minimum necessary to accomplish the intended purpose of such disclosure.

Section 3. Security Standards. CHLIC shall use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to Electronic PHI to prevent use or disclosure of PHI other than as provided for by the Agreement.

Section 4. Protection of Electronic PHI. With respect to Electronic PHI, CHLIC shall:

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

(B) Ensure that any agent or subcontractor to whom CHLIC provides Electronic PHI agrees to implement reasonable and appropriate safeguards to protect such information; and,

(C) CHLIC shall promptly report to the Plan any Security Incident with respect to Electronic PHI of which it becomes aware and which has compromised the protections set forth in the HIPAA Security Rule. In the event of a Security Incident, CHLIC shall report to the Plan in writing (i) any actual, successful Security Incident within ten (10) business days of the date on which CHLIC first becomes aware of such actual, successful Security Incident and (ii) to the extent commercially reasonable, the Plan may request CHLIC to report in writing attempted but unsuccessful Security Incidents involving PHI of which CHLIC becomes aware, provided however that such reports are not required for trivial and routine incidents such as port scans, attempts to log-in with an invalid password or user name, denial of service attacks that do not result in a server being taken off-line, malware and pings or other similar types of events.

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

Section 6. Security Breach Notification. CHLIC will notify the Plan of a Breach (including privacy related incidents that might, upon further investigation, be deemed to be a Breach) without unreasonable delay and, in any event, within ten (10) business days after CHLIC's discovery of same. This notification will include, to the extent known:

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

ii. the circumstances surrounding the Breach;

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

iv. the information Breached;

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

vi. the steps CHLIC is taking to investigate the Breach, mitigate losses, and protect against future Breaches; and,

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

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

Section 7. Disclosures to and Agreements with Third Parties. CHLIC agrees to ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of CHLIC agree to the same restrictions, conditions and requirements that apply to CHLIC with respect to such information.

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

Section 9. Availability of PHI for Amendment. CHLIC shall respond to a request by an Individual for amendment to such Individual's PHI contained in a Designated Record Set in the time and manner required in 45 C.F.R. §164.526.

Section 10. Right to Confidential Communications and to Request Restriction of Disclosures of PHI. CHLIC shall respond to a request by an Individual for confidential communications or to restrict the uses and disclosures of PHI contained in such Individual's Designated Record Set in the time and manner required by 45 C.F.R. §164.522. CHLIC shall not be obligated to agree to, or implement, any restriction, if such restriction would hinder Health Care Operations or the provision of the functions, activities or services, unless such restriction would otherwise be required by 45 C.F.R. § 164.522(a).

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

Section 12. Availability of Books and Records. CHLIC hereby agrees to make its internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by CHLIC on behalf of the Plan, available to the Secretary for purposes of determining the Plan's compliance with the Privacy Rule.

Section 13. Standard Transactions. CHLIC certifies that it conducts any applicable transactions that are subject to the HIPAA standard transaction rules (45 C.F.R. Parts 160-164) as required under such rules.

IV. TERMINATION OF AGREEMENT WITH CHLIC

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

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

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

V. OBLIGATIONS OF THE PLAN AND PLAN SPONSOR

Section 1. Disclosures Generally. Except as otherwise provided for in this Addendum, the Plan will not request that CHLIC use or disclose PHI in any manner that would not be permissible under HIPAA or HITECH if done by the Plan.

Section 2. Disclosures to the Plan or Third Parties. To the extent the Plan requests that CHLIC disclose PHI either to the Plan or to a third party acting for the Plan, the Plan represents and warrants that:

(A) It only will request PHI for the purposes of Treatment, Payment, or Health Care Operations, or another permitted purpose under the HIPAA Privacy Rule;

(B) The information requested is the minimum necessary to achieve the purpose of the disclosure; and

(C) If the PHI is to be disclosed to a third party, the Plan has a business associate agreement in place with the third party, where required.

Section 3. Disclosure to Plan Sponsor. To the extent the Plan requests that CHLIC to disclose PHI to the Plan Sponsor, the Plan and Plan Sponsor each represent and warrant that:

(A) The information only will be used for one of the following purposes:

i. Plan Administration functions, as defined by the HIPAA Privacy Rule, and that the Plan Sponsor has executed the required plan amendment and certification allowing the disclosure, as set out in the HIPAA Privacy Rule;

ii. Enrollment functions, provided the information to be disclosed is limited to enrollment and disenrollment information; or

iii. To amend, modify, or terminate the Plan, or to obtain premium bids to provide health insurance coverage under the Plan, provided the information to be disclosed is limited to Summary Health Information, as defined in the HIPAA Privacy Rule; and

(B) The information requested is the minimum necessary to achieve the purpose of the disclosure.

VI. DEFINITIONS FOR USE IN THIS ADDENDUM

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

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

"Business Associate" means CHLIC.

"Covered Entity" means the Plan.

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

"Effective Date" shall mean the effective date of the Agreement.

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

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

"Protected Health Information" or **"PHI"** shall have the same meaning as set forth at 45 C.F.R. §160.103.

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

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

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

Exhibit E – Conditional Claim/Subrogation Recovery Services

I. Plans Without CHLIC General Stop Loss Coverage

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

A. All conditional claim payment and/or subrogation recoveries under the Plan will be handled by the entity checked below;

___ Employer
___ An independent recovery vendor whose name and address follow:
___ CHLIC and its subcontractor(s)

B. If Employer has designated CHLIC and its subcontractors to act as its recovery agent in paragraph I.A. above, then:

i. Employer hereby confers upon CHLIC and its subcontractors' discretionary authority to reduce recovery amounts by as much as fifty percent (50%) of the total amount of benefits paid on Employer's behalf, and to enter into binding settlement agreements for such amounts.

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

Name:
Title:
Address:
Telephone:

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

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

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

II. Plans with CHLIC Stop Loss Coverage

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

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

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

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

APPENDIX A

Cigna Home Delivery Pharmacy Standard-Level Specialty Drug List

THIS SPECIALTY DRUG LIST IS CONFIDENTIAL, PROPRIETARY INFORMATION OF CIGNA. IT IS PROVIDED SOLELY FOR EMPLOYER'S PLAN ADMINISTRATION PURPOSES. RE-DISCLOSURE IS STRICTLY PROHIBITED. CIGNA RESERVES ALL LEGAL RIGHTS AND REMEDIES TO ENFORCE THESE PROHIBITIONS ON USE AND DISCLOSURE.

Currently Marketed Specialty Drugs on this Specialty Drug List. The discounts in this Specialty Drug List are the discounts that will be adjudicated in Cigna's claim processing system for the drug indicated when dispensed by Cigna Home Delivery Pharmacy, subject to all of the following.

- Any or all of the discounts in this Specialty Drug List may be adjusted by Cigna in the event of a major change in market conditions affecting the pharmaceutical or pharmacy benefit management market, a drug shortage in the market, an issue involving the safety of the drug supply, or similar market situation.

- The discounts in this Specialty Drug List are based on the terms and design of the Pharmacy Benefit that Employer has adopted and disclosed to Cigna. Accordingly, if Employer fails to disclose to Cigna, for example, that it uses or intends to use a consumer-driven health plan, a major cost-sharing program, or a utilization management program promoting generic or OTC drugs over brand drugs, Cigna may adjust the discounts.

- The discounts in this Specialty Drug List shall not apply to compound drug claims, claims that process at U&C, and direct member reimbursement (DMR) claims.

- Any or all of the discounts in this Specialty Drug List may be adjusted by Cigna if (a) there are any significant changes in the composition of Cigna's pharmacy network or in Cigna's pharmacy network contract compensation rates, or the structure of the pharmacy stores/chains/vendors that are contracted with Cigna, including but not limited to disruption in the retail pharmacy delivery model, or bankruptcy of a chain pharmacy; or (b) there is a change in government laws or regulations which has a significant impact on pharmacy claim costs; or (c) any material manufacturer-rebate contracts with or for the benefit of Cigna are terminated or modified in whole or in part; or (d) there is any legal action or Law that materially affects or could materially affect the manner in which Cigna's rebate program is administered or an existing Law is interpreted so as to materially affect or potentially have a material effect on Cigna's administration of the Pharmacy Benefit; or (e) there is a material change in the Plan or the Plan's Pharmacy Benefit that is initiated by Employer which impacts Cigna's costs.

New-to-Market Specialty Products. Specialty Drug Claims that are for new-to-market drugs will have a minimum market-introduction guaranteed discount of 11.45% off the drug's AWP.

Condition	Brand Name	Rate
ALS	RILUTEK	13.54%
AMD	EYLEA	11.45%
ANGIOEDEMA	FIRAZYR	11.45%
Anti-coagulant	INNOHEP	11.45%
ANTI-INFECTIVE	BETHKIS	11.45%
ANTI-INFECTIVE	CYTOGAM	11.45%
ANTI-INFECTIVE	CYTOVENE	11.45%
ANTI-INFECTIVE	FUZEON	11.45%
ANTI-INFECTIVE	TOBI	11.45%
ANTI-INFECTIVE	TOBI PODHALER	13.54%
ANTI-INFECTIVE	VISTIDE	11.45%
Antithrombin III deficiency	ATRYN	11.45%
ASTHMA	XOLAIR	11.45%
CANCER - ANCILLARY/ADJUVANT	ALOXI	11.45%
CANCER - ANCILLARY/ADJUVANT	ANZEMET	11.45%
CANCER - ANCILLARY/ADJUVANT	ARANESP	11.45%
CANCER - ANCILLARY/ADJUVANT	COMETRIQ	13.54%
CANCER - ANCILLARY/ADJUVANT	ELIGARD	11.45%
CANCER - ANCILLARY/ADJUVANT	ELITEK	11.45%
CANCER - ANCILLARY/ADJUVANT	EMEND	13.54%
CANCER - ANCILLARY/ADJUVANT	EPOGEN	11.45%
CANCER - ANCILLARY/ADJUVANT	ETHYOL	11.45%
CANCER - ANCILLARY/ADJUVANT	FIRMAGON	11.45%
CANCER - ANCILLARY/ADJUVANT	FUSILEV	11.45%
CANCER - ANCILLARY/ADJUVANT	GRANIX	11.45%
CANCER - ANCILLARY/ADJUVANT	LEUCOVORIN CALCIUM	13.54%
CANCER - ANCILLARY/ADJUVANT	LEUKINE	11.45%
CANCER - ANCILLARY/ADJUVANT	LUPANETA	11.45%
CANCER - ANCILLARY/ADJUVANT	LUPRON DEPOT	11.45%
CANCER - ANCILLARY/ADJUVANT	MESNEX	11.45%
CANCER - ANCILLARY/ADJUVANT	NEULASTA	11.45%
CANCER - ANCILLARY/ADJUVANT	NEUMEGA	11.45%
CANCER - ANCILLARY/ADJUVANT	NEUPOGEN	11.45%
CANCER - ANCILLARY/ADJUVANT	PROCRIT	11.45%
CANCER - ANCILLARY/ADJUVANT	SUPPRELIN LA	11.45%
CANCER - ANCILLARY/ADJUVANT	VANTAS	11.45%
CANCER - ANCILLARY/ADJUVANT	VORAXAZE	11.45%
CANCER - ANCILLARY/ADJUVANT	ZOLADEX	11.45%
CANCER - CHEMOTHERAPY	ABRAXANE	11.45%

CANCER - CHEMOTHERAPY	ADCETRIS	15.00%
CANCER - CHEMOTHERAPY	ADRIAMYCIN	11.45%
CANCER - CHEMOTHERAPY	ADRIAMYCIN RDF	11.45%
CANCER - CHEMOTHERAPY	AFINITOR	13.54%
CANCER - CHEMOTHERAPY	AFINITOR DISPERZ	13.54%
CANCER - CHEMOTHERAPY	AGRYLIN	13.54%
CANCER - CHEMOTHERAPY	ALIMTA	11.45%
CANCER - CHEMOTHERAPY	ALKERAN	11.45%
CANCER - CHEMOTHERAPY	ARRANON	11.45%
CANCER - CHEMOTHERAPY	ARZERRA	11.45%
CANCER - CHEMOTHERAPY	AVASTIN	11.45%
CANCER - CHEMOTHERAPY	BEXXAR	11.45%
CANCER - CHEMOTHERAPY	BICNU	11.45%
CANCER - CHEMOTHERAPY	BOSULIF	13.54%
CANCER - CHEMOTHERAPY	BUSULFEX	11.45%
CANCER - CHEMOTHERAPY	CAMPATH	11.45%
CANCER - CHEMOTHERAPY	CAMPTOSAR	11.45%
CANCER - CHEMOTHERAPY	CAPRELSA	11.45%
CANCER - CHEMOTHERAPY	CASODEX	13.54%
CANCER - CHEMOTHERAPY	CERUBIDINE	11.45%
CANCER - CHEMOTHERAPY	CLOLAR	11.45%
CANCER - CHEMOTHERAPY	COSMEGEN	11.45%
CANCER - CHEMOTHERAPY	DACOGEN	11.45%
CANCER - CHEMOTHERAPY	DAUNOXOME	11.45%
CANCER - CHEMOTHERAPY	DEPOCYT	11.45%
CANCER - CHEMOTHERAPY	DOCEFREZ	11.45%
CANCER - CHEMOTHERAPY	DOXIL	11.45%
CANCER - CHEMOTHERAPY	DOXORUBICIN HCL	16.66%
CANCER - CHEMOTHERAPY	DTIC-DOME IV	38.00%
CANCER - CHEMOTHERAPY	ELLENCE	11.45%
CANCER - CHEMOTHERAPY	ELOXATIN	11.45%
CANCER - CHEMOTHERAPY	ELSPAR	11.45%
CANCER - CHEMOTHERAPY	EMCYT	13.54%
CANCER - CHEMOTHERAPY	ERBITUX	11.45%
CANCER - CHEMOTHERAPY	ERIVEDGE	13.54%
CANCER - CHEMOTHERAPY	ERWINAZE	11.45%
CANCER - CHEMOTHERAPY	ETOPOPHOS	11.45%
CANCER - CHEMOTHERAPY	FASLODEX	11.45%
CANCER - CHEMOTHERAPY	FLUDARA	11.45%
CANCER - CHEMOTHERAPY	FOLOTYN	11.45%
CANCER - CHEMOTHERAPY	FUDR	11.45%

CANCER - CHEMOTHERAPY	GEMZAR	11.45%
CANCER - CHEMOTHERAPY	GLEEVEC	13.54%
CANCER - CHEMOTHERAPY	GLIADEL	12.92%
CANCER - CHEMOTHERAPY	HALAVEN	11.45%
CANCER - CHEMOTHERAPY	HERCEPTIN	11.45%
CANCER - CHEMOTHERAPY	HEXALEN	13.54%
CANCER - CHEMOTHERAPY	HYCAMTIN	13.54%
CANCER - CHEMOTHERAPY	ICLUSIG	13.54%
CANCER - CHEMOTHERAPY	IDAMYCIN PFS	11.45%
CANCER - CHEMOTHERAPY	IFEX	11.45%
CANCER - CHEMOTHERAPY	INLYTA	9.00%
CANCER - CHEMOTHERAPY	IRESSA	13.54%
CANCER - CHEMOTHERAPY	ISTODAX	11.45%
CANCER - CHEMOTHERAPY	IXEMPRA	11.45%
CANCER - CHEMOTHERAPY	JEVTANA	11.45%
CANCER - CHEMOTHERAPY	KYPROLIS	11.45%
CANCER - CHEMOTHERAPY	LEUSTATIN	11.45%
CANCER - CHEMOTHERAPY	MARQIBO KIT	11.45%
CANCER - CHEMOTHERAPY	MATULANE	13.54%
CANCER - CHEMOTHERAPY	MEKINIST	13.54%
CANCER - CHEMOTHERAPY	MITHRACIN	11.45%
CANCER - CHEMOTHERAPY	MUSTARGEN	11.45%
CANCER - CHEMOTHERAPY	MYLOTARG	11.45%
CANCER - CHEMOTHERAPY	NAVELBINE	11.45%
CANCER - CHEMOTHERAPY	NEXAVAR	11.45%
CANCER - CHEMOTHERAPY	NEXAVIR	11.45%
CANCER - CHEMOTHERAPY	NIPENT	11.45%
CANCER - CHEMOTHERAPY	NOVANTRONE	11.45%
CANCER - CHEMOTHERAPY	OFORTA	17.00%
CANCER - CHEMOTHERAPY	ONCASPAR	11.45%
CANCER - CHEMOTHERAPY	ONTAK	11.45%
CANCER - CHEMOTHERAPY	PANRETIN	11.45%
CANCER - CHEMOTHERAPY	PERJETA	11.45%
CANCER - CHEMOTHERAPY	POMALYST	13.54%
CANCER - CHEMOTHERAPY	PROLEUKIN	11.45%
CANCER - CHEMOTHERAPY	PROVENGE	11.45%
CANCER - CHEMOTHERAPY	REVLIMID	5.00%
CANCER - CHEMOTHERAPY	RITUXAN	11.45%
CANCER - CHEMOTHERAPY	SPRYCEL	13.54%
CANCER - CHEMOTHERAPY	STIVARGA	13.54%
CANCER - CHEMOTHERAPY	SUPPRELIN	11.45%

CANCER - CHEMOTHERAPY	SUTENT	13.54%
CANCER - CHEMOTHERAPY	SYLATRON	11.45%
CANCER - CHEMOTHERAPY	SYLATRON 4-PACK	11.45%
CANCER - CHEMOTHERAPY	SYNRIBO	11.45%
CANCER - CHEMOTHERAPY	TAFINLAR	13.54%
CANCER - CHEMOTHERAPY	TARCEVA	13.54%
CANCER - CHEMOTHERAPY	TARGRETIN	13.54%
CANCER - CHEMOTHERAPY	TASIGNA	13.54%
CANCER - CHEMOTHERAPY	TAXOTERE	11.45%
CANCER - CHEMOTHERAPY	TEMODAR	13.54%
CANCER - CHEMOTHERAPY	THALOMID	13.54%
CANCER - CHEMOTHERAPY	TORISEL	11.45%
CANCER - CHEMOTHERAPY	TREANDA	11.45%
CANCER - CHEMOTHERAPY	TRELSTAR	11.45%
CANCER - CHEMOTHERAPY	TRELSTAR DEPOT	11.45%
CANCER - CHEMOTHERAPY	TRELSTAR LA	11.45%
CANCER - CHEMOTHERAPY	TRISENOX	11.45%
CANCER - CHEMOTHERAPY	TYKERB	13.54%
CANCER - CHEMOTHERAPY	VALCHLOR	11.45%
CANCER - CHEMOTHERAPY	VALSTAR	11.45%
CANCER - CHEMOTHERAPY	VECTIBIX	11.45%
CANCER - CHEMOTHERAPY	VELCADE	11.45%
CANCER - CHEMOTHERAPY	VIDAZA	11.45%
CANCER - CHEMOTHERAPY	VOTRIENT	13.54%
CANCER - CHEMOTHERAPY	VUMON	11.45%
CANCER - CHEMOTHERAPY	XALKORI	11.45%
CANCER - CHEMOTHERAPY	XELODA	13.54%
CANCER - CHEMOTHERAPY	XTANDI	13.54%
CANCER - CHEMOTHERAPY	YERVOY	11.45%
CANCER - CHEMOTHERAPY	ZALTRAP	11.45%
CANCER - CHEMOTHERAPY	ZANOSAR	11.45%
CANCER - CHEMOTHERAPY	ZELBORAF	13.54%
CANCER - CHEMOTHERAPY	ZEVALIN	11.45%
CANCER - CHEMOTHERAPY	ZOLINZA	13.54%
CANCER - CHEMOTHERAPY	ZYTIGA	11.45%
CANCER-CEHMOTHERAPY	GILOTRIF	13.54%
CANCER-CHEMOTHERAPY	CYRAMZA	11.45%
CANCER-CHEMOTHERAPY	GAZYVA	11.45%
CANCER-CHEMOTHERAPY	IMBRUVICA	13.54%
CANCER-CHEMOTHERAPY	ZYKADIA	13.54%
CHRONIC KIDNEY DISEASE	OMONTYS	11.45%

CYSTIC FIBROSIS	KALYDECO	13.54%
Cystinosis	CYSTAGON	13.54%
ENZYME DISORDER	ADAGEN	11.45%
ENZYME DISORDER	ALDURAZYME	0.00%
ENZYME DISORDER	ARALAST	11.45%
ENZYME DISORDER	ARALAST NP	13.54%
ENZYME DISORDER	CEREDASE	0.00%
ENZYME DISORDER	CEREZYME	0.00%
ENZYME DISORDER	ELAPRASE	11.45%
ENZYME DISORDER	ELELYSO	11.45%
ENZYME DISORDER	FABRAZYME	0.00%
ENZYME DISORDER	GLASSIA	11.45%
ENZYME DISORDER	LUMIZYME	0.00%
ENZYME DISORDER	LUMIZYME	11.45%
ENZYME DISORDER	MYOZYME	0.00%
ENZYME DISORDER	NAGLAZYME	11.45%
ENZYME DISORDER	PROCYSBI DR	13.54%
ENZYME DISORDER	PROLASTIN	11.45%
ENZYME DISORDER	PROLASTIN C	11.45%
ENZYME DISORDER	SUCRAID	15.00%
ENZYME DISORDER	VIMIZIM	11.45%
ENZYME DISORDER	VPRIV	0.00%
ENZYME DISORDER	ZAVESCA	13.54%
ENZYME DISORDER	ZEMAIRA	11.45%
GROWTH HORMONE DEFICIENCY	EGRIFTA	11.45%
GROWTH HORMONE DEFICIENCY	GATTEX	11.45%
GROWTH HORMONE DEFICIENCY	GENOTROPIN	11.45%
GROWTH HORMONE DEFICIENCY	HUMATROPE	11.45%
GROWTH HORMONE DEFICIENCY	INCRELEX	0.00%
GROWTH HORMONE DEFICIENCY	NORDITROPIN	11.45%
GROWTH HORMONE DEFICIENCY	NORDITROPIN FLEXPRO	11.45%
GROWTH HORMONE DEFICIENCY	NORDITROPIN NORDIFLEX	11.45%
GROWTH HORMONE DEFICIENCY	NUTROPIN	11.45%
GROWTH HORMONE DEFICIENCY	NUTROPIN AQ	11.45%
GROWTH HORMONE DEFICIENCY	NUTROPIN AQ NUSPIN	11.45%
GROWTH HORMONE DEFICIENCY	OMNITROPE	11.45%
GROWTH HORMONE DEFICIENCY	SAIZEN	11.45%
GROWTH HORMONE DEFICIENCY	SEROSTIM	11.45%
GROWTH HORMONE DEFICIENCY	TEV-TROPIN	11.45%
GROWTH HORMONE DEFICIENCY	ZORBTIVE	11.45%
HEMOPHILIA	ADVATE	23.95%

HEMOPHILIA	ADVATE H	23.95%
HEMOPHILIA	ADVATE L	23.95%
HEMOPHILIA	ADVATE M	23.95%
HEMOPHILIA	ADVATE SH	23.95%
HEMOPHILIA	ADVATE UH	23.95%
HEMOPHILIA	ALPHANATE	32.00%
HEMOPHILIA	ALPHANINE SD	39.58%
HEMOPHILIA	ALPROLIX	11.00%
HEMOPHILIA	AMICAR	13.54%
HEMOPHILIA	BEBULIN	11.45%
HEMOPHILIA	BEBULIN VH IMMUNO	41.66%
HEMOPHILIA	BENEFIX	6.25%
HEMOPHILIA	CORIFACT	11.45%
HEMOPHILIA	CYKLOKAPRON	11.45%
HEMOPHILIA	FEIBA NF	38.54%
HEMOPHILIA	FEIBA VH IMMUNO	38.54%
HEMOPHILIA	HELIXATE FS	31.25%
HEMOPHILIA	HEMOFIL M	43.75%
HEMOPHILIA	HUMATE-P	11.45%
HEMOPHILIA	KOATE-DVI	30.20%
HEMOPHILIA	KOGENATE FS	36.45%
HEMOPHILIA	LYSTEDA	11.45%
HEMOPHILIA	MONOCLATE-P	28.12%
HEMOPHILIA	MONONINE	11.45%
HEMOPHILIA	NOVOSEVEN	26.50%
HEMOPHILIA	NOVOSEVEN	35.41%
HEMOPHILIA	NOVOSEVEN RT	26.50%
HEMOPHILIA	PROFILNINE SD	42.70%
HEMOPHILIA	RECOMBINATE	37.50%
HEMOPHILIA	RIXUBIS	42.70%
HEMOPHILIA	STIMATE	11.45%
HEMOPHILIA	THROMBATE III	11.45%
HEMOPHILIA	TRETTEN	11.45%
HEMOPHILIA	WILATE	11.45%
HEMOPHILIA	XYNTHA	30.00%
HEMOPHILIA	XYNTHA SOLOFUSE	30.00%
HEPATITIS B	BARACLUDE	13.54%
HEPATITIS B	HEPAGAM B	11.45%
HEPATITIS B	HEPSERA	13.54%
HEPATITIS B	HYPERHEP B S-D	11.45%
HEPATITIS B	NABI-HB	11.45%

HEPATITIS B	TYZEKA	13.54%
HEPATITIS C	ALFERON N	11.45%
HEPATITIS C	COPEGUS	13.54%
HEPATITIS C	INCIVEK	11.45%
HEPATITIS C	INFERGEN	11.45%
HEPATITIS C	INTRON A	11.45%
HEPATITIS C	OLYSIO	13.54%
HEPATITIS C	PEGASYS	11.45%
HEPATITIS C	PEGASYS PROCLICK	11.45%
HEPATITIS C	PEGINTRON	11.45%
HEPATITIS C	PEGINTRON REDIPEN	11.45%
HEPATITIS C	REBETOL	13.54%
HEPATITIS C	RIBAPAK	13.54%
HEPATITIS C	RIBASPHERE	75.00%
HEPATITIS C	RIBATAB	13.54%
HEPATITIS C	SOVALDI	13.54%
HEPATITIS C	VICTRELIS	13.54%
HIV	APTIVUS	13.54%
HIV	ATRIPLA	13.54%
HIV	COMBIVIR	13.54%
HIV	COMPLERA	13.54%
HIV	CRIXIVAN	13.54%
HIV	EDURANT	13.54%
HIV	EMTRIVA	13.54%
HIV	EPIVIR	13.54%
HIV	EPIVIR HBV	13.54%
HIV	EPZICOM	13.54%
HIV	INTELENCE	11.45%
HIV	INVIRASE	13.54%
HIV	ISENTRESS	13.54%
HIV	KALETRA	13.54%
HIV	LEXIVA	13.54%
HIV	NORVIR	13.54%
HIV	PREZISTA	13.54%
HIV	RESCRIPTOR	13.54%
HIV	RETROVIR	11.45%
HIV	REYATAZ	13.54%
HIV	SELZENTRY	13.54%
HIV	STRIBILD	13.54%
HIV	SUSTIVA	13.54%
HIV	TIVICAY	13.54%

HIV	TRIZIVIR	13.54%
HIV	TRUVADA	13.54%
HIV	VIDEX	13.54%
HIV	VIDEX EC	13.54%
HIV	VIRACEPT	13.54%
HIV	VIRAMUNE	13.54%
HIV	VIRAMUNE XR	13.54%
HIV	VIREAD	13.54%
HIV	ZERIT	13.54%
HIV	ZIAGEN	13.54%
Homocystinuria	CYSTADANE	13.54%
IMIG	BAYGAM	11.45%
IMIG	GAMASTAN S-D	11.45%
INFERTILITY	BRAVELLE	11.45%
INFERTILITY	CETROTIDE	13.00%
INFERTILITY	FERTINEX	17.00%
INFERTILITY	FOLLISTIM AQ	13.00%
INFERTILITY	GONAL-F	13.00%
INFERTILITY	GONAL-F RFF	13.00%
INFERTILITY	LUTREPULSE	11.45%
INFERTILITY	LUVERIS	11.45%
INFERTILITY	MENOPUR	13.00%
INFERTILITY	NOVAREL	13.00%
INFERTILITY	OVIDREL	13.00%
INFERTILITY	PREGNYL	13.00%
INFERTILITY	PROFASI	17.00%
INFERTILITY	REPRONEX	13.00%
IVIG	BIVIGAM	27.08%
IVIG	CARIMUNE NF NANOFILTERED	30.00%
IVIG	FLEBOGAMMA	27.08%
IVIG	FLEBOGAMMA DIF	27.08%
IVIG	GAMMAGARD	27.08%
IVIG	GAMMAGARD LIQUID	27.08%
IVIG	GAMMAGARD S-D	27.08%
IVIG	GAMMAKED	27.08%
IVIG	GAMMAPLEX	27.08%
IVIG	GAMUNEX	27.08%
IVIG	GAMUNEX-C	24.00%
IVIG	HIZENTRA	27.00%
IVIG	OCTAGAM	27.08%
IVIG	PRIVIGEN	11.45%

IVIG	VIVAGLOBIN	11.45%
MULTIPLE SCLEROSIS	AMPYRA	12.00%
MULTIPLE SCLEROSIS	AUBAGIO	12.00%
MULTIPLE SCLEROSIS	AVONEX	11.45%
MULTIPLE SCLEROSIS	AVONEX ADMINISTRATION PACK	11.45%
MULTIPLE SCLEROSIS	AVONEX PEN	11.45%
MULTIPLE SCLEROSIS	BETASERON	11.45%
MULTIPLE SCLEROSIS	COPAXONE	11.45%
MULTIPLE SCLEROSIS	EXTAVIA	11.45%
MULTIPLE SCLEROSIS	GILENYA	11.89%
MULTIPLE SCLEROSIS	REBIF	11.45%
MULTIPLE SCLEROSIS	REBIF REBIDOSE	11.46%
MULTIPLE SCLEROSIS	TECFIDERA	12.00%
MULTIPLE SCLEROSIS	TYSABRI	11.45%
MYELOFIBROSIS	JAKAFI	13.54%
OTHER	ACTHAR H.P.	8.55%
OTHER	ACTHREL	11.45%
OTHER	ACTIMMUNE	11.45%
OTHER	ARCALYST	11.45%
OTHER	AREDIA	13.54%
OTHER	ARIXTRA	11.45%
OTHER	BERINERT	11.45%
OTHER	BONIVA	11.45%
OTHER	BOTOX	11.45%
OTHER	BOTOX COSMETIC	11.45%
OTHER	CINRYZE	11.45%
OTHER	DDAVP	11.45%
OTHER	DYSPORT	11.45%
OTHER	EXJADE	13.54%
OTHER	FORTEO	11.45%
OTHER	FRAGMIN	11.45%
OTHER	HP ACTHAR	8.55%
OTHER	HYALGAN	11.45%
OTHER	HYLENEX	0.00%
OTHER	HYPERRAB S-D	11.45%
OTHER	ILARIS	11.45%
OTHER	IMOGAM RABIES-HT	11.45%
OTHER	IPRIVASK	11.45%
OTHER	JETREA	11.45%
OTHER	JUXTAPID	13.54%
OTHER	KALBITOR	11.45%

OTHER	KCENTRA	11.45%
OTHER	KCENTRA KIT	11.45%
OTHER	KRYSTEXXA	11.45%
OTHER	KUVAN	11.45%
OTHER	KYNAMRO	11.45%
OTHER	LOVENOX	11.45%
OTHER	LUCENTIS	11.45%
OTHER	MACUGEN	11.45%
OTHER	MONOVISC	11.45%
OTHER	MOZOBIL	11.45%
OTHER	MYALEPT	11.45%
OTHER	MYOBLOC	11.45%
OTHER	NATRECOR	11.45%
OTHER	NPLATE	11.45%
OTHER	ORFADIN	13.54%
OTHER	ORTHOVISC	11.45%
OTHER	PHOTOFRIN	11.45%
OTHER	PRIALT	11.45%
OTHER	PROLIA	11.45%
OTHER	PROMACTA	13.54%
OTHER	PULMOZYME	11.45%
OTHER	RECLAST	11.45%
OTHER	REFLUDAN	11.45%
OTHER	RIASTAP	11.45%
OTHER	SABRIL	13.54%
OTHER	SANDOSTATIN	11.45%
OTHER	SANDOSTATIN LAR	11.45%
OTHER	SENSIPAR	13.54%
OTHER	SIGNIFOR	11.45%
OTHER	SOLIRIS	11.45%
OTHER	SOMATULINE DEPOT	11.45%
OTHER	SOMAVERT	11.45%
OTHER	SYNAREL	11.45%
OTHER	SYNVISC	11.45%
OTHER	SYNVISC-ONE	11.45%
OTHER	THYROGEN	11.45%
OTHER	VIRAZOLE	11.45%
OTHER	VISUDYNE	11.45%
OTHER	VIVITROL	11.45%
OTHER	XENAZINE	13.54%
OTHER	XEOMIN	11.45%

OTHER	XGEVA	11.45%
OTHER	XIAFLEX	11.45%
OTHER	XYREM	13.54%
OTHER	ZEMPLAR	11.45%
OTHER	ZOMETA	11.45%
OTHER - Immunomodulator	AZASAN	13.54%
OTHER - Immunomodulator	IMURAN	13.54%
OTHER - Immunomodulator	OTREXUP	11.45%
OTHER - Immunomodulator	RHEUMATREX	13.54%
OTHER - Immunomodulator	THERACYS	11.45%
OTHER - Immunomodulator	TREXALL	13.54%
Parkinson's disease	APOKYN	11.45%
Protein C deficiency	CEPROTIN	11.45%
PSORIASIS	AMEVIVE	11.45%
PSORIASIS	STELARA	9.00%
PULMONARY ARTERIAL HYPERTENSION	ADCIRCA	13.54%
PULMONARY ARTERIAL HYPERTENSION	ADEMPAS	13.54%
PULMONARY ARTERIAL HYPERTENSION	FLOLAN	11.45%
PULMONARY ARTERIAL HYPERTENSION	LETAIRIS	11.45%
PULMONARY ARTERIAL HYPERTENSION	OPSUMIT	13.54%
PULMONARY ARTERIAL HYPERTENSION	ORENITRAM ER	13.54%
PULMONARY ARTERIAL HYPERTENSION	REMODULIN	11.45%
PULMONARY ARTERIAL HYPERTENSION	REVATIO	11.45%
PULMONARY ARTERIAL HYPERTENSION	TRACLEER	11.46%
PULMONARY ARTERIAL HYPERTENSION	TYVASO	11.45%
PULMONARY ARTERIAL HYPERTENSION	VELETRI	2.50%
PULMONARY ARTERIAL HYPERTENSION	VENTAVIS	6.25%
RA	KINERET	11.45%
RA	ORENCIA	11.45%
RA	XELJANZ	13.54%
RA/IBD	CIMZIA	11.45%
RA/JIA	ORENCIA	11.45%
RA/JIA/PSOA/AS/PSORIASIS	ACTEMRA	11.45%
RA/JIA/PSOA/AS/PSORIASIS	ENBREL	11.45%
RA/JIA/PSOA/AS/PSORIASIS	ENTYVIO	11.45%
RA/JIA/PSOA/AS/PSORIASIS	OTEZLA	13.54%
RA/JIA/PSOA/AS/PSORIASIS/IBD	HUMIRA	11.45%
RA/PSOA/AS	SIMPONI ARIA	11.45%
RA/PSOA/AS	SIMPONI	11.45%
RA/PSOA/AS/PSORIASIS/IBD	REMICADE	11.45%
RESPIRATORY SYNCYTIAL VIRUS	SYNAGIS	12.50%

RHO(D) IMMUNE GLOBULIN	HYPERRHO S-D	11.45%
RHO(D) IMMUNE GLOBULIN	MICRHOGAM	11.45%
RHO(D) IMMUNE GLOBULIN	MICRHOGAM PLUS	11.45%
RHO(D) IMMUNE GLOBULIN	RHOGAM	11.45%
RHO(D) IMMUNE GLOBULIN	RHOGAM PLUS	11.45%
RHO(D) IMMUNE GLOBULIN	RHOPHYLAC	11.45%
RHO(D) IMMUNE GLOBULIN	WINRHO SDF	11.45%
Systemic lupus erythematosus	BENLYSTA	11.45%
TRANSPLANT	ASTAGRAF XL	13.54%
TRANSPLANT	ATGAM	11.45%
TRANSPLANT	CELLCEPT	13.54%
TRANSPLANT	KEPIVANCE	11.45%
TRANSPLANT	MYFORTIC	13.54%
TRANSPLANT	NEORAL	13.54%
TRANSPLANT	NULOJIX	11.45%
TRANSPLANT	ORTHOCLONE OKT-3	11.45%
TRANSPLANT	PROGRAF	13.54%
TRANSPLANT	RAPAMUNE	13.54%
TRANSPLANT	SANDIMMUNE	11.45%
TRANSPLANT	SIMULECT	11.45%
TRANSPLANT	THYMOGLOBULIN	11.45%
TRANSPLANT	ZORTRESS	13.54%

Condition	Brand Name	Average Rate
ALS	RILUZOLE	83.02%
Anti-coagulant	ARGATROBAN	40.00%
ANTI-INFECTIVE	CIDOFOVIR	40.00%
ANTI-INFECTIVE	GANCICLOVIR SODIUM	40.00%
ANTI-INFECTIVE	TOBRAMYCIN	22.87%
CANCER - ANCILLARY/ADJUVANT	AMIFOSTINE	40.00%
CANCER - ANCILLARY/ADJUVANT	LEUCOVORIN CALCIUM	46.00%
CANCER - ANCILLARY/ADJUVANT	LEUPROLIDE ACETATE	40.02%
CANCER - ANCILLARY/ADJUVANT	MESNA	40.00%
CANCER - CHEMOTHERAPY	ADRIAMYCIN	15.00%
CANCER - CHEMOTHERAPY	ADRUCIL	16.77%
CANCER - CHEMOTHERAPY	ANAGRELIDE HCL	95.53%
CANCER - CHEMOTHERAPY	AZACITIDINE	16.71%
CANCER - CHEMOTHERAPY	BCG VACCINE (TICE STRAIN)	40.00%
CANCER - CHEMOTHERAPY	BICALUTAMIDE	93.48%
CANCER - CHEMOTHERAPY	BLEOMYCIN SULFATE	11.87%
CANCER - CHEMOTHERAPY	CAPECITABINE	20.42%
CANCER - CHEMOTHERAPY	CARBOPLATIN	11.00%
CANCER - CHEMOTHERAPY	CISPLATIN	1.04%
CANCER - CHEMOTHERAPY	CLADRIBINE	16.66%
CANCER - CHEMOTHERAPY	CYCLOPHOSPHAMIDE	76.38%
CANCER - CHEMOTHERAPY	CYTARABINE	11.53%
CANCER - CHEMOTHERAPY	DACARBAZINE	40.00%
CANCER - CHEMOTHERAPY	DACTINOMYCIN	40.00%
CANCER - CHEMOTHERAPY	DAUNORUBICIN	40.00%
CANCER - CHEMOTHERAPY	DECITABINE	16.66%
CANCER - CHEMOTHERAPY	DOCETAXEL	11.00%
CANCER - CHEMOTHERAPY	DOXORUBICIN	15.00%
CANCER - CHEMOTHERAPY	DOXORUBICIN HCL	15.00%
CANCER - CHEMOTHERAPY	EPIRUBICIN	40.00%
CANCER - CHEMOTHERAPY	EPIRUBICIN HCL	40.00%
CANCER - CHEMOTHERAPY	ETOPOSIDE	15.11%
CANCER - CHEMOTHERAPY	FLOXURIDINE	40.00%
CANCER - CHEMOTHERAPY	FLUDARABINE PHOSPHATE	40.00%
CANCER - CHEMOTHERAPY	FLUOROURACIL	16.77%
CANCER - CHEMOTHERAPY	FLUTAMIDE	41.33%
CANCER - CHEMOTHERAPY	GEMCITABINE HCL	40.00%
CANCER - CHEMOTHERAPY	IDARUBICIN HCL	40.00%
CANCER - CHEMOTHERAPY	IFOSFAMIDE	40.00%

CANCER - CHEMOTHERAPY	IFOSFAMIDE-MESNA	40.00%
CANCER - CHEMOTHERAPY	IRINOTECAN HCL	16.61%
CANCER - CHEMOTHERAPY	LIPODOX 50	15.00%
CANCER - CHEMOTHERAPY	MELPHALAN HCL	40.00%
CANCER - CHEMOTHERAPY	METHOTREXATE	15.00%
CANCER - CHEMOTHERAPY	MITOMYCIN	40.00%
CANCER - CHEMOTHERAPY	MITOXANTRONE HCL	40.00%
CANCER - CHEMOTHERAPY	ONXOL	11.00%
CANCER - CHEMOTHERAPY	OXALIPLATIN	31.84%
CANCER - CHEMOTHERAPY	PACLITAXEL	11.00%
CANCER - CHEMOTHERAPY	PENTOSTATIN	40.00%
CANCER - CHEMOTHERAPY	TEMOZOLOMIDE	25.77%
CANCER - CHEMOTHERAPY	TENIPOSIDE	40.00%
CANCER - CHEMOTHERAPY	THIOTEPA	40.00%
CANCER - CHEMOTHERAPY	TOPOSAR	30.55%
CANCER - CHEMOTHERAPY	TOPOTECAN HCL	40.00%
CANCER - CHEMOTHERAPY	TOPOTECAN HCL	40.00%
CANCER - CHEMOTHERAPY	VANDETANIB	40.00%
CANCER - CHEMOTHERAPY	VINBLASTINE SULFATE	40.00%
CANCER - CHEMOTHERAPY	VINCASAR PFS	11.98%
CANCER - CHEMOTHERAPY	VINCRISTINE	34.65%
CANCER - CHEMOTHERAPY	VINCRISTINE SULFATE	34.65%
CANCER - CHEMOTHERAPY	VINORELBINE	40.00%
CANCER - CHEMOTHERAPY	VINORELBINE TARTRATE	40.00%
HEMOPHILIA	AMINOCAPROIC ACID	50.91%
HEMOPHILIA	TRANEXAMIC ACID	15.00%
HEPATITIS B	ADEFOVIR DIPIVOXIL	15.00%
HEPATITIS C	MODERIBA	84.17%
HEPATITIS C	RIBAPAK	20.11%
HEPATITIS C	RIBASPHERE	89.98%
HEPATITIS C	RIBAVIRIN	89.98%
HIV	ABACAVIR	15.00%
HIV	ABACAVIR-LAMIVUDINE-ZIDOV	15.00%
HIV	DIDANOSINE	15.00%
HIV	LAMIVUDINE	15.00%
HIV	LAMIVUDINE	15.00%
HIV	LAMIVUDINE-ZIDOVUDINE	26.64%
HIV	NEVIRAPINE	92.31%
HIV	STAVUDINE	64.15%
HIV	ZIDOVUDINE	78.60%
INFERTILITY	CHORIONIC GONADOTROPIN	15.00%

INFERTILITY	GANIRELIX ACETATE	13.01%
IVIG	GAMMAPLEX	40.00%
IVIG	PRIVIGEN	40.00%
MULTIPLE SCLEROSIS	EXTAVIA	11.45%
OTHER	DESMOPRESSIN	15.00%
OTHER	DESMOPRESSIN ACETATE	15.00%
OTHER	ENOXAPARIN	52.73%
OTHER	ENOXAPARIN SODIUM	52.50%
OTHER	EUFLEXXA	9.38%
OTHER	FONDAPARINUX SODIUM	14.49%
OTHER	GEL-ONE	9.38%
OTHER	IBANDRONATE	40.00%
OTHER	OCTREOTIDE ACETATE	21.96%
OTHER	PAMIDRONATE	40.00%
OTHER	PAMIDRONATE DISODIUM	40.00%
OTHER	PARICALCITOL	15.00%
OTHER	PROVISC	19.09%
OTHER	SUPARTZ	9.38%
OTHER	ZOLEDRONIC ACID	15.00%
OTHER - Immunomodulator	AZATHIOPRINE	58.29%
OTHER - Immunomodulator	METHOTREXATE	50.05%
OTHER - Immunomodulator	METHOTREXATE SODIUM	29.84%
PULMONARY ARTERIAL HYPERTENSION	EPOPROSTENOL SODIUM	40.00%
PULMONARY ARTERIAL HYPERTENSION	SILDENAFIL	90.98%
TRANSPLANT	CYCLOSPORINE	41.91%
TRANSPLANT	CYCLOSPORINE MODIFIED	15.00%
TRANSPLANT	GENGRAF	15.50%
TRANSPLANT	HECORIA	36.92%
TRANSPLANT	MYCOPHENOLATE	88.23%
TRANSPLANT	MYCOPHENOLATE MOFETIL	88.23%
TRANSPLANT	MYCOPHENOLIC ACID	15.00%
TRANSPLANT	MYCOPHENOLIC ACID DR	15.00%
TRANSPLANT	SIROLIMUS	15.00%
TRANSPLANT	TACROLIMUS	36.92%

Victoria A. Sirica
Contractual Agreement Unit Manager
Cigna

Routing B2CAU
900 Cottage Grove Road
Hartford, CT 06152
Telephone 860.226.2785
Facsimile 860.730.3944
Victoria.sirica@cigna.com

May 11, 2015

John Capetanakis
Vice President, Compensation & Benefits
City of Santa Fe
6 High Ridge Park
Stamford, CT 06905

Re: Administrative Services Only Agreement by and between Cigna Health and Life Insurance Company ("**CHLIC**") and City of Santa Fe ("**Employer**")

Dear Mr. Capetanakis:

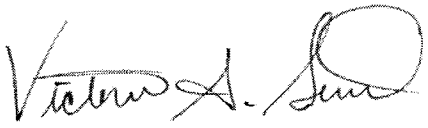
Enclosed is an Administrative Services Only Agreement (the "**Agreement**") that CHLIC has prepared to establish the terms under which it will administer a self-funded benefit plan on behalf of Employer beginning July 1, 2015 (the "**Effective Date**").

Employer may signify its acceptance of the terms of the Agreement by:

- Executing (i) this letter (where indicated below), or (ii) the signature page in the Agreement, and returning the executed page to me at the above address, or
- Taking no action, in which case the Agreement shall become binding upon Employer and CHLIC sixty (60) days following the date of this letter.

If Employer does not accept all the terms of the enclosed Agreement, it must so notify CHLIC either electronically or in writing (at the address indicated above) within sixty (60) days of the date of this letter. In that case, CHLIC shall cooperate to negotiate mutually agreeable terms with Employer. Once a subsequent agreement is finalized, it will apply retroactively to the Effective Date. Until then, however, the enclosed Agreement, which may periodically be amended by CHLIC, will govern the relationship between Employer and CHLIC.

The following information is required to implement the New York Public Goods Pool (New York Health Care Reform Act of 1996). Without receipt of this election information by the 15th day of the month PRIOR to the effective date claims will be adjudicated as non-elect and will not be re-adjudicated upon the subsequent receipt of the required information.

CIGNA Health and Life Insurance Company	***City of Santa Fe***
By: 	By: _____
Authorized Representative: Victoria A. Sirica	Authorized Representative: _____
Title: Contractual Agreement Unit Manager	Title: _____
Date: May 11, 2015	Date: _____

"Cigna" is a registered service mark and the "Tree of Life" logo is a service mark of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

FOR INFORMATIONAL PURPOSES REGARDING YOUR NYHCRA ELECTION STATUS

NEW YORK HEALTH CARE REFORM ACT ELECTION STATUS

The following information is required to implement Exhibit B of the ASO Agreement regarding the New York Public Goods Pool (New York Health Care Reform Act of 1996). Without receipt of this election information by the 15th day of the month PRIOR to the effective date, claims will be adjudicated as non-elect and will not be re-adjudicated upon the subsequent receipt of the required information.

Employer is:

[X] **Currently elect with the NY Public Goods Pool under the following name and Tax ID number.** CHLIC will act as ( ) the sole or ( ) an additional TPA for the following medical coverage(s):

_____

_____ _____

Name Tax ID Number

Previous TPA(s) being replaced by Cigna (if applicable):

_____

Run out claims will be handled by previous TPA until :_____(Date)

[ ] **Currently non-elect, but chooses to elect to the New York Public Goods Pool under the following name and tax identification number** with CHLIC as ( ) the sole or ( ) an additional TPA for the following medical coverage(s):

_____

_____ _____

Name Tax ID Number

_____ _____ _____

Address Contact Phone

As required by the State of New York, the undersigned agrees to the following:
By signature below, the above entity elects to make all public goods surcharge payments directly to the Office of Pool Administration for all its coverages for which it assumes risk for payment of medical claims and agrees to:

1. remit to the Department's Office of Pool Administration required surcharge payments for all applicable services on a monthly basis on or before the 30th day following the calendar month for which monies have been paid to designated providers of service;

2. provide the Department's Office of Pool Administration monthly certified reports on or before the 30th day following the calendar month for which monies have been paid which separately report patient service expenditures for services provided by designated provider type(s) (i.e., hospital inpatient, hospital outpatient, diagnostic & treatment center, laboratory, or ambulatory surgery center) by product line;

3. provide the Department with certification of data and access to allowance expenditure data upon request for audit verification purposes: and

4. the jurisdiction of the state to maintain an action in the courts of the State of New York to enforce any provision of section 2807-j of the Public Health Law (see note below).

5. the Department's website posting of the above entity's FEIN in accordance with Public Health Law Section 2807-j(5)(a)(iii)(D).

By signature below, the above entity also agrees to make public goods covered lives payments directly to the Department's Office of Pool Administration in instances where it provides inpatient coverage as a corporation organized and operating in accordance with Article 43 of the Insurance Law, an organization operating in accordance with Article 44 of the Public Health Law, a self-insured fund, or an HMO or insurer licensed outside New York State and authorized to write accident and health insurance and whose policy provides inpatient coverage on an expense incurred basis. In such instances the above entity agrees to:

1. remit to the Department's Office of Pool Administration within 30 days after the end of each month one-twelfth of both the individual and family unit annual assessment amounts for each of the individuals and family units residing in the state which were included on the payor's membership rolls for all or a portion of the prior month and for which the payor covered general hospital inpatient care, including retroactive additions and deletions;

2. provide the Department with data certification and access to individual and family unit data, upon request, for audit verification purposes; and

3. the jurisdiction of the state to maintain an action in the courts of the State of New York to enforce any provision of section 2807-t of the Public Health Law. Note: *Payors making an election are only agreeing to the jurisdiction of NYS courts for purposes of enforcing payments required under 2807-j and 2807-t. This does not, in any way, preclude a payor from litigating other issues in Federal court such as ERISA based challenges, etc.*

[ ] **Currently non-elect and chooses to continue that non-elect status.**

[ ] **Currently elect, but CHLIC will not administer NYHCRA liability.**

Please sign below to indicate your acknowledgement of this arrangement.

SIGNATURE:

_____	_____	_____
Name	Title	Date

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL
INSTRUCTIONS

All electing payors/third party administrators (TPA)/administrative services only (ASO) organizations and designated providers are required to file Public Goods Pool reports electronically. This also applies to the 1% Statewide Assessment report filed by hospitals. To file electronically, you must establish an electronic filing account and be assigned a secure password. A website has been established at www.hcrapools.org to facilitate this process.

While electronic filing is designed to be user friendly, a help desk has been established to aid those users requiring assistance. If you need general assistance or assistance in obtaining copies of the electronic filing screens and the electronic reporting certification forms, please contact the help desk at (315) 671-3800 or via email at webpools@hcrapools.org.

Upon receipt of a fully completed Electronic Filing User ID Application (DOH-4264), the Office of Pool Administration will assign a secure electronic filing user ID and password to your organization, which you will receive via return mail.

New Request/Revision to Existing Account: Check the appropriate box. An entity requesting an initial account/password should check the *New Request* box; an entity that has an existing account and is advising the Department of a change to that account should check the *Revision to Existing Account* box.

Payor/TPA/ASO/Provider Name: Enter name of entity that will be submitting the reports electronically.

Federal Employer Identification Number (FEIN): Enter FEIN assigned to the entity named above.

Operating Certificate #: (For providers only): Enter Operating Certificate number assigned by the Department of Health to the entity named above.

Report(s) being filed electronically (check ALL applicable types): Check all applicable types of reports that your entity will be filing electronically – Public Goods Pool and/or Statewide Assessment.

Signature: Must be signed by the Chief Executive/Financial Officer and/or Administrator of the entity named above.

Name/Title/Phone Number (Please Print): Enter name, title and phone number of the person signing above.

Address/City/State/Zip Code: Enter address of the person signing above.

E-mail Address: Enter e-mail address of the person signing above.

Date: Enter date this form is signed.

FOR INFORMATIONAL PURPOSES REGARDING YOUR NYHCRA ELECTION STATUS

NEW YORK STATE DEPARTMENT OF HEALTH
Division of Health Care Financing

Electronic Filing User ID Application

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

☐ **New Request** ☐ **Revision to Existing Account**

Payor/Third Party Administrator/Administrative Services Only Organization/Provider Name:

_____

Federal Employer Identification # (FEIN): _____

Operating Certificate # (FOR PROVIDERS ONLY): _____N/A_____

Report(s) being filed electronically (check ALL that apply):

- **X** Public Goods Pool
- ☐ 1% Statewide Assessment **(for hospitals only)**

By signature below, the Chief Financial Officer or other duly authorized individual of the above named entity authorizes the Office of Pool Administration to assign a secure electronic filing user ID and password to the entity. This information will be mailed directly to the attention of the signer and must remain secured. It is the responsibility of the above named entity to ensure that this information is released only to those individuals requiring knowledge thereof.

Signature _____

Name (Please Print) _____

Title _____

Phone Number _____

Address _____

_____

City _____ **State** _____ **Zip Code** _____

E-mail Address _____

Date _____

Note: All fields on this form are required to be accurately completed in order for your request to be processed.

Please mail completed form to:
Mr. Jerome Alaimo, Pool Administrator
Office of Pool Administration
Excellus BlueCross BlueShield, Central New York Region
P.O. Box 4757
Syracuse, New York 13221-4757

FOR INFORMATIONAL PURPOSES REGARDING YOUR NYHCRA ELECTION STATUS

NEW YORK HEALTHCARE REFORM ACT (NYHCRA) SURCHARGE & ASSESSMENTS

NYHCRA BASIC INFORMATION:

The New York Health Care Reform Act (NYHCRA) establishes a system of surcharges and covered lives assessments in order to fund uncompensated care, professional medical education, and other health care initiatives. The amount of liability is determined by the election status of the payor. A payor is either "Elect" or "Non-Elect." Insured clients are automatically 'Elect'. Administrative Services Only (ASO) clients must decide whether to 'Elect' and allow Cigna to pay the surcharge liability directly to the New York Public Goods Pool during claim payment or to pay it themselves at a higher cost.

EMPLOYER RESPONSIBILITY & CIGNA RECOMMENDATION

It is ultimately the Employer's responsibility to ensure they understand NYHCRA and complete the appropriate election paperwork. Employers must register with the State of New York a NYHCRA election status of either 'Elect" or 'Non-Elect'. There are two components to each of the status choices:

- Elect employers pay to the State of New York Public Goods Pool a patient services charge per affected claim plus a covered lives assessment.

- Non-Elect employers pay a surcharge directly to the New York provider of services per claim plus an additional percentage of the inpatient facility claim amount for Graduate Medical Education (GME).

Cigna, as the Third Party Administrator (TPA) payor for your claims, recommends that all of our ASO clients register as 'Elect' and pay the surcharge to the Public Goods Pool. **There are significant financial savings for an 'Elect' client.**

- Effective 4/1/2009, the patient services surcharge for an elect payor is 9.63%. Covered Lives Assessment amounts vary by region, depending on the employee's residence, and they also vary by whether the employee has individual or family coverage. Surcharge and covered lives assessments are calculated and paid monthly by Cigna to the Public Goods Pool on behalf of the employer.

- Non-Electors do not pay to the Public Goods Pool and their liability is based solely on affected claims incurred with a New York provider. They pay a surcharge of 37.90% to the provider of services and instead of paying a Covered Lives Assessment, they also pay an additional Graduate Medical Education (GME) Tax on inpatient facility claims. The GME amount varies from 2.25% to 27.28% depending on the region. As a result of the GME, the surcharge on an inpatient claim may be as high as 65%.

Due to the significant savings, we have indicated your status as "elect"on the attached Letter of Intent.

If you choose not to 'Elect', a waiver form must be signed. The waiver indicates that you have been advised of NYHCRA requirements but choose to remain 'Non-Elect'. Please contact your Sales representative if you would like to change the status which has been pre-selected for you.

Victoria A. Sirica
Contractual Agreement Unit Manager
Cigna

Routing B2CAU
900 Cottage Grove Road
Hartford, CT 06152
Telephone 860.226.2785
Facsimile 860.730.3944
Victoria.Sirica@cigna.com

June 15, 2016

Victoria Gage
Assistant Director Human Resource Department
City of Santa Fe
200 Lincoln Avenue
Santa Fe, NM 87501

RE: Administrative Services Only Account No. 3338881

Dear Ms. Gage:

This letter will serve as an amendment to the Administrative Services Only Agreement between Cigna Health and Life Insurance Company ("CHLIC") and City of Santa Fe ("Employer"), effective July 1, 2015 (the "Agreement").

Effective as of July 1, 2016, 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.

"Definitions," of the Administrative Services Only Agreement, is hereby amended to add the following definition to the existing section as follows:

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

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

d. CHLIC will promptly adjust any underpayment of Plan Benefits by drawing additional funds due the claimant from the Bank Account. In the event CHLIC overpays a claim for Plan Benefits or pays Plan Benefits to the wrong party, it shall take all reasonable steps to recover the overpayments. CHLIC shall not be required to initiate court, mediation, arbitration or other administrative proceedings to recover any overpayment. However, when it elects to do so, CHLIC is expressly authorized by Employer to take all actions on behalf of the Employer and/or the Plan to pursue overpayment recovery, including, but not limited to, retaining counsel, settling and compromising claims, in which case CHLIC shall be responsible for the attorney fees, court costs or arbitration fees incurred by CHLIC in the specific overpayment recovery action (not applicable to subrogation or conditional claim payment recoveries), but not any other associated third party costs absent consent of CHLIC. CHLIC shall not be responsible for reimbursing any unrecovered payments of Plan Benefits unless made as a result of its gross negligence or intentional wrongdoing.

Sections 4.b and 4.c of the Administrative Services Only Agreement are hereby amended in their entirety as follows:

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.

"Cigna" is a registered service mark, and the "Tree of Life" logo is a service mark, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

c. Retroactive Changes and Terminations. Employer shall remain responsible for all applicable charges and Bank Account Payments incurred or charged through the date CHLIC processed Employer's notice of a retroactive change or termination of a Member. However, if the change or termination would result in a reduction in charges, CHLIC shall credit to Employer the reduction in charges charged for the shorter of (a) the sixty (60) day period preceding the date CHLIC processes the notice, or (b) the period from the date of the change or termination to the date CHLIC processes the notice.

Section 8, "Modification of Plan and Charges," of the Administrative Services Only Agreement is hereby amended to add provision c. to the existing language as follows:

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

Sections 12.b and 12.c of the Administrative Services Only Agreement are hereby amended in their entirety as follows:

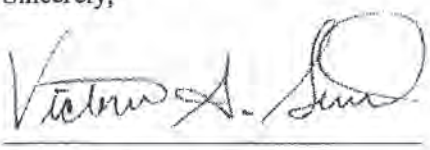
b. In the event that a Controversy has not been resolved within thirty-five (35) calendar days of the request of Executive Review under Section 12.a, above, the disputing Party shall initiate mediation by providing written notice to the other Party, which shall be conducted in Hartford, Connecticut, in accordance with the American Arbitration Association Commercial Mediation Rules ("**Mediation**"). Each Party shall assume its own costs and attorneys' fees, and the compensation and expenses of the mediator and any administrative fees or costs associated with the mediation proceeding shall be borne equally by the Parties.

c. In the event that a Controversy has not been resolved by Executive Review or Mediation, the Controversy shall be settled exclusively by binding arbitration. The arbitration shall be conducted in the same location as noted in Section 12.b. above, in accordance with the American Arbitration Association Commercial Arbitration Rules, and which to the extent of the subject matter of the arbitration, shall be binding not only on all Parties to this Agreement but on any other entity controlled by, in control of or under common control with the Party to the extent that such affiliate joins in the arbitration, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Each Party shall assume its own costs and attorneys' fees, and the compensation and expenses of the arbitrator and any administrative fees or costs associated with the arbitration proceeding shall be borne equally by the Parties. The decision of the arbitrator shall be final, conclusive and binding, and no action at law or in equity may be instituted by either Party other than to enforce the award of the arbitrator.

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

The terms of the Administrative Services Only Agreement identified above, as mentioned herein, will be effective as of July 1, 2016. Please indicate your agreement to the amendment by signing the enclosed copy of this letter where indicated and returning it to me. Alternatively, this amendment shall become effective on the effective date indicated unless Employer notifies CHLIC either electronically or in writing (at the address indicated above) within sixty (60) days of the date of this letter that it does not accept all the terms of this amendment notwithstanding any provision to the contrary in the Administrative Services Only Agreement. In that case, CHLIC shall cooperate to negotiate mutually agreeable terms with Employer. Once agreement with respect to the terms of the amendment is reached, the amendment will apply retroactively to the effective date.

Sincerely,



Victoria A. Sirica
Its Contractual Agreement Unit Manager
Duly Authorized
Cigna Health and Life Insurance Company

Accepted by: **CITY OF SANTA FE**

By: _____

Name: _____

Title: _____

Executed this ____ day of _____, in the year _____.

Schedule of Financial Charges

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

	MEDICAL/DENTAL ADMINISTRATION CHARGES	
Product	**Description**	**Charge**
Medical	• Open Access Plus (OAP) with PHS Plus Medical Management	**$33.88/employee/month**
Medical	• HRA Open Access Plus (OAP) with PHS Plus Medical Management	**$38.82/employee/month**
Dental	• Dental Preferred Provider Organization (DPPO)	**$3.45/employee/month**
MEDICAL/DENTAL NETWORK ACCESS FEE, UTILIZATION MANAGEMENT FEE AND OPTIONAL PROGRAM FEE		
Product	**Description**	**Charge**
Medical	• OAP Access Fee	**$17.75/employee/month Included in Medical Administration Charge**
Medical	• HRA OAP Access Fee	**$17.75/employee/month Included in Medical Administration Charge**
Dental	• DPPO Access Fee	**$0.80/employee/month Included in Dental Administration Charge**
	MULTI-YEAR CHARGE/FEE GUARANTEES	
	The maximum increase for the Medical Administration Charge(s) and Network Access Fee(s) for the 2017 Plan Year will be 2.00% over the 2016 Plan Year charges/fees. The maximum increase for the Medical Administration Charge(s) and Network Access Fee(s) for the 2018 Plan Year will be 2.00% over the 2017 Plan Year charges/fees. The above fee guarantees are not applicable to Pharmacy Administration Fee. The above charges/fees are guaranteed for the time periods identified above, provided, however, that CHLIC may revise the above charges/fees pursuant to Section 8 of this Agreement.	

CIGNA CHOICE FUND AND OTHER CONSUMER DIRECTED ACCOUNT ADMINISTRATION SERVICES AND CHARGES		
	Product	**Charge**
	• Cigna Choice Fund Health Reimbursement Account (HRA) Administration	**$4.94/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. • 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 Members to provide coaching for those identified with gaps for high cholesterol, high blood pressure • Support of Participants identified through predictive modeling with certain preference sensitive care conditions by supplying impartial evidence based medical information, to empower Participants' to understand the potential benefits/ disadvantages of a specific course of action and make more informed care decisions. • Answering health and medical related questions • Counseling Participants on prevention and the benefits of compliance with prescribed medications and treatments	**For HRA OAP Only Included in Medical Access Fee**
	• Dependent Care Flexible Spending Account (DFSA) Administration	**Included at No Additional Cost**
	• Health Care Flexible Spending Account (FSA) Administration	**$5.79/employee/month**
AMOUNTS OWED TO CHLIC		
Amounts paid by CHLIC with its own funds on behalf of Employer or the Plan with respect to charges for which Employer or the Plan is obligated to pay under this Agreement including Plan Benefits, Bank Account Payments (including fix per person payments and pay-for-performance payments to Participating Providers), governmental taxes or assessments.		

	CIGNA PHARMACY BENEFIT MANAGEMENT SERVICES CHARGES AND RELATED PROVISIONS	

Definitions

- "Average Wholesale Price" or "AWP" is the Average Wholesale Price for a given pharmaceutical product in effect on the dispense date for the actual package size dispensed as published by Medi-Span or other alternative publication or benchmark reasonably designated by CHLIC.
- "Brand Drug Claim" is a claim for a pharmaceutical product that is adjudicated as a brand drug as indicated on the claim record generated by the claim processing system used by CHLIC. For application of discounts and dispensing fees, a "Brand Drug Claim" includes a claim for a generic drug within its exclusivity period or other period of limited competition, as CHLIC reasonably determines under its standard policies. Except if and where the language expressly states otherwise, a Brand Drug Claim does not include a Specialty Brand Drug Claim.
- "Dispensing Fee" means an amount paid to a pharmacy for providing professional services necessary to dispense medication to a Member.
- "Drug Claim" is a claim for a pharmaceutical product.
- "Generic Drug Claim" is a claim for a pharmaceutical product that is adjudicated as a generic drug as indicated on the claim record generated by the claim processing system used by CHLIC. For application of discounts and dispensing fees, a "Generic Drug Claim" excludes a claim for a generic drug within its exclusivity period or other period of limited competition, as CHLIC reasonably determines under its standard policies. Except if and where the language expressly states otherwise, a Generic Drug Claim does not include a Specialty Generic Drug Claim.
- "Mail", when immediately preceding the term "Brand Drug Claim," "Generic Drug Claim," "Specialty Drug Claim," "Specialty Brand Drug Claim, or "Specialty Generic Drug Claim" means that the resulting term (e.g., "Mail Brand Drug Claim") refers to such claim as dispensed by a Mail Service Pharmacy.
- "Mail Service Pharmacy" or "Cigna Tel-Drug" or "Cigna Home Delivery Pharmacy" is a pharmacy that is owned or operated by Connecticut General or an affiliated company(ies) (currently, Tel-Drug, Inc. and Tel-Drug of Pennsylvania, LLC), which dispenses drugs covered under the Plan's Pharmacy Benefit by mail, and is not a Retail Pharmacy.
- "Maximum Allowable Charge" means the list of drugs designated from lists established by CHLIC for which reimbursement to a pharmacy shall be paid according to the MAC price established by CHLIC for such list.
- "Pharmacy Benefit" means the terms of the Plan that govern coverage and care/utilization management of drugs and related supplies dispensed to Members and charged to the Plan by the Mail Service Pharmacy or Retail Pharmacies through CHLIC's pharmacy claim processing system.
- "Rebates" or "Manufacturer Formulary Payments" means amounts that CHLIC collects under contracts with drug manufacturers that are based on utilization of certain of the manufacturers' brand drugs under the Plan's Pharmacy Benefit and the drug's status on the Cigna drug formulary.

- "Retail", when immediately preceding the term "Brand Drug Claim," "Generic Drug Claim," "Specialty Drug Claim," "Specialty Brand Drug Claim, or "Specialty Generic Drug Claim" means that the resulting term (e.g., "Retail Brand Drug Claim") refers to such claim as dispensed by a Retail Pharmacy.
- "Retail Pharmacy" is a pharmacy that is entitled to payment under the Plan for drugs it dispenses that are covered under the Plan's Pharmacy Benefit, and is not a Mail Service Pharmacy.
- "Specialty Drug Claim" is a claim for a pharmaceutical product that is reasonably determined by CHLIC to be a specialty drug in accordance with industry practice. Specialty drugs generally are (i) injected or infused and derived from living cells, or are oral non-protein compounds (e.g., oral chemotherapy drugs); (ii) target the underlying condition, which is usually one of a relatively rare, chronic and costly nature; and/or (iii) require restricted access and/or close monitoring.
- "Specialty Brand Drug Claim" means a claim for a pharmaceutical product that is adjudicated, as indicated on the claim record generated by the claim processing system used by CHLIC, as a brand drug which is also a specialty drug.
- "Specialty Generic Drug Claim" means a claim for a pharmaceutical product that is adjudicated, as indicated on the claim record generated by the claim processing system used by CHLIC, as a generic drug which is also a specialty drug.

PHARMACY ADMINISTRATION FEE

- Cigna Pharmacy Product Administration Fee: This fee is separate from the Medical Administration Charge shown above, but included on same billing line as the Medical Administration Charge for billing purposes only

CHARGES FOR DRUGS COVERED UNDER THE PLAN'S PHARMACY BENEFIT

Drugs Dispensed by Mail Service Pharmacy: CHLIC will charge Employer the following for claims covered under the Plan's Pharmacy Benefit and dispensed by the Mail Service Pharmacy, subject to the "Drug Charges – Additional Provisions" section:

Brand Drug Claims: AWP minus an average discount of 20.00%.

Generic Drug Claims: The drug's charge on a CHLIC generic Maximum Allowable Charge schedule that generates an annual average aggregate discount across Generic Drug Claims dispensed at Cigna Home Delivery Pharmacy to CHLIC group-client book of business of AWP minus 74.50%.

Specialty Drug Claims: The drug's charge discounted as shown in the Cigna Home Delivery Pharmacy Specialty Drug List, attached as Appendix A hereto.

Home Delivery Drug Claims: An average dispensing fee of no more than $0.00.

Drugs Dispensed by Retail Pharmacies: CHLIC will charge Employer the following for drugs covered under the Plan's Pharmacy Benefit and dispensed by a Retail Pharmacy to the Plan Members, subject to the "Drug Charges – Additional Provisions" section:

Retail Brand Drug Claims: The lesser of (i) AWP minus an average discount of 17.10%; or (ii) the Retail Pharmacy's usual and customary charge.

Retail Generic Drug Claims (other than those to which the above brand discount applies): The lesser of: (i) the drug's charge on a CHLIC generic Maximum Allowable Charge schedule that generates an annual average aggregate discount across Generic Drug Claims dispensed at Retail Pharmacies to CHLIC group-client book of business of AWP minus 72.00% (Plan-specific results may vary based on drug mix); or (ii) the Retail Pharmacy's usual and customary charge.

Retail Specialty Generic Drug Claims: The drug's charge discounted as shown in the Specialty Drug List, attached as Appendix A hereto.

Retail Specialty Brand Drug Claims: The lesser of (i) AWP minus an annual average aggregate discount of 10.50%; or (ii) the Retail Pharmacy's usual and customary charge.

Retail Drug Claims: An average dispensing fee of no more than $1.40, except in the case of usual and customary claims, for which no dispensing fee is charged.

DRUG CHARGES – ADDITIONAL PROVISIONS

- Cigna Home Delivery Pharmacy's discounts are applied to the manufacturer average wholesale price (AWP) for the dispensed size (or to the AWP for the manufacturer-packaged quantity closest to the dispensed size, if there is no AWP for the dispensed size).
- The amount paid to the Retail Pharmacy for Brand, Generic, or Specialty Drug Claims may or may not be equal to the amount charged to Employer, and CHLIC will absorb or retain any difference.
- An excess achieved in any Plan-specific discount floor or dispensing fee cap offered under this Agreement will be used to offset a shortfall in any other Plan-specific discount floor or dispensing fee cap offered under this Agreement.
- Industry Changes to or Replacement of Average Wholesale Price (AWP). Notwithstanding any other provision in this Agreement, including in this Exhibit, in the event of any major change in market conditions affecting the pharmaceutical or pharmacy benefit management market, including, for example, any change in the markup, methodologies, processes or algorithms underlying the published AWP(s), CHLIC may adjust any or all of the charges, rates, discounts, guarantees and/or fees in connection with CHLIC's administration of the Plan's Pharmacy Benefit hereunder, including any that are based on AWP, as it reasonably deems necessary to preserve the economic value or benefit of this Agreement as it existed immediately prior to such change. Additionally, and notwithstanding any other provision in this Agreement, including in this Exhibit, CHLIC may replace AWP as its pharmaceutical pricing benchmark with an alternative benchmark and/or may replace Medi-Span, or other such publication as its source for the AWP or alternative benchmark with a different pricing source, provided that CHLIC adjusts any or all such AWP-Based Charges or such alternative benchmark-based charges as it reasonably deems necessary to preserve the economic value or benefit of this Agreement as it existed immediately prior to such replacement or immediately prior to the event(s) giving rise to such replacement, as the case may be.

DRUG MANUFACTURER-PAYMENT SHARING
Subject to the caveats below, CHLIC will remit to Employer the following portion of Rebates that CHLIC collects with respect to utilization under the Plan's Pharmacy Benefit: $26.27 per Retail Pharmacy Brand Drug Claim and $128.01 per Mail Service Pharmacy Brand Drug Claim
Caveats: (1) Upon termination of this Agreement, CHLIC may apply Rebates otherwise payable to offset Bank Account or other deficits of charges identified in this Agreement. (2) Should Employer terminate this Agreement before completion of the then-current Plan Year, no Rebates shall be due with respect to that Plan Year as Rebates are based on completion of an entire Plan Year. (3) All applicable caveats communicated in writing by CHLIC in connection with its proposal made in connection with this Agreement are hereby incorporated by reference. (4) For percentage-based sharing arrangements, payout amount may differ slightly from the stated percentage when payout occurs before manufacturers' final reconciliations and payments are made to CHLIC. (5) Rebates are not paid out on Run-Out Claims or on claims for drugs covered under the federal 340B drug pricing program. (6) CHLIC or its agent contracts with drug manufacturers on CHLIC's own behalf, and not as agent of the Employer or the Plan. Timing of Rebate Pay-Out: Remittance will be provided within ninety (90) days after the close of each applicable calendar year for the portion of such calendar year that coincides with the Plan Year.
AUDIT RIGHTS RELATED TO MANUFACTURER PAYMENTS
Employer's third party auditor may audit records directly related to CHLIC's performance of its obligations hereunder regarding sharing of manufacturer formulary payments (a/k/a "rebates") once in each twelve-month period upon the following conditions: Employer shall provide at least forty-five (45) days written notice to CHLIC; the auditor (including its individual auditors conducting the audit) shall be agreeable to Employer and CHLIC; a mutually agreed upon non-disclosure/non-use contract shall be executed by Employer, the auditor and CHLIC; the records to be audited shall be no more than two years old as of the date of the audit; the scope of records to be audited shall be as mutually agreed upon by Employer's third party auditor and CHLIC as those which are necessary to determine compliance with the rebate-sharing obligations under this Agreement; the audit shall be conducted at a mutually acceptable time during regular business hours at CHLIC's office where such records are located; records shall not be removed or photocopied without CHLIC's express written consent; the auditor shall provide its audit report to CHLIC and Employer at the same time; and the auditor may disclose the aggregate amount of manufacturer formulary payments due Employer but no other details of CHLIC's manufacturer contracts of which the auditor is apprised, if any.

FEES FOR PROCESSING RUN-OUT CLAIMS		
OAP, HRA OAP and DPPO	Run-Out Period of twelve (12) months	**No Additional Cost**
Pharmacy	Run-Out Period of three (3) months for all pharmacy claims	**No Additional Cost**
SUBROGATION		
	Subrogation/Conditional Claim Payment. Identification, investigation and recovery of claim payments involving other party liability or where another entity is responsible for payment (including by way of example but not by limitation automobile insurance, homeowner insurance, commercial property insurance, worker's compensation). (This service is only provided with respect to Medical coverage).	**5% of recovery plus litigation costs if counsel is retained and an appearance is filed on behalf of CHLIC or Employer in any litigation, or a lawsuit is filed on their behalf;** **29% of recovery if no counsel is retained and in all other instances, including cases where state law requires that employee benefit plans be named as party defendants or involuntary plaintiffs.**

CHLIC COST CONTAINMENT FEES

CHLIC, a Cigna company, administers the following programs to contain costs with respect to charges for health care service/supplies that are covered by the Plan. In administering these programs, CHLIC contracts with vendors to perform program related services. Specific vendor fees are available upon request. CHLIC's charge for administering these programs is the percentage (indicated below) of either (1) the "net savings" (i.e. the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings, less the applicable vendor fee which generally ranges from 7-11% of the program savings) or (2) the "gross savings" (i.e. the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings; CHLIC pays the applicable vendor fee) or (3) the "recovery" (i.e. the amount recovered) as applicable.

For charges for covered services received from a non-Participating Provider (including emergency/urgent care services that are covered at the in-network benefit level), CHLIC may apply discounts available under agreements with third parties or through negotiation of the billed charges. These programs are identified below as the Network Savings Program, Supplemental Network & Medical Bill Review (pre-payment). CHLIC charges the percentage shown for administering these programs. Applying these discounts may result in higher payments than if the maximum reimbursable charge is applied. Whereas application of the maximum reimbursable charge may result in the patient being balance billed for the entire unreimbursed amount, applying these discounts avoids balance billing and substantially reduces the patient's out-of pocket cost.

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

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

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

a. the amount of provider's billed charge not exceeding the greater of a CHLIC determined percentage of the Medicare allowable amount (the 80th percentile of the reasonable and customary charge if there is no Medicare allowable charge) or the amount required by state or federal, law (in the case of emergency room services) for charges subject to CHLIC's benefit enhancement policy (patient may be balance billed by the provider if the provider's charge exceeds such amount), or

b. the provider's billed charge.

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

MEDICAL AND PHARMACY COST CONTAINMENT		
1.	Network Savings Program	**29% of net savings**
2.	Supplemental Network	**29% of net savings**
3.	Medical Bill Review – (Pre-payment Cost Containment for Non-contracted claims):	
	Inpatient Hospital Bill Review	

	• Line Item Analysis	**Lesser of 5% of hospital bill or the savings achieved**
	• Professional Fee Negotiation	**29% of net savings**
	Outpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
	Physician/Professional Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
4.	Medical Bill Review – (Pre or Post-payment Cost Containment for Non-contracted and Contracted claims):	
	• Bill Audit	**29% of the savings/recovery achieved plus hospital fees or expenses passed through**
	Diagnosis Related Grouping (DRG) Validation/Audits and Recovery. An overpayment audit and recovery program in which CHLIC or its vendors review paid claim data to identify overpayments based on inaccurate DRG coding.	**29% of recovery plus any fees or expenses passed through by the hospital or regulatory agency**
	Inpatient Admission Retrospective Review	**29% of recovery**
	Medical Implant Device Audits	**29% of recovery**
5.	COB Vendor Recoveries [Exclusive of pharmacy programs where claims are adjudicated at time prescription is received.]	**29% of recovery**
6.	Secondary Vendor Recovery Program	**29% of recovery**
7.	Provider Credit Balance Recovery Program	**29% of recovery**
8.	High Cost Specialty Pharmaceutical Audits (this service is only provided with respect to Medical coverage)	**29% of recovery**
9.	Pharmacy Vendor Recoveries	**30% of recovery**
10.	Class Action Recoveries	**35% of recovery**

DENTAL COST CONTAINMENT		
	Dental Cost Containment	**25% of gross savings**
CARE MANAGEMENT/COST CONTAINMENT PROGRAM FEES		
	CHLIC arranges for third parties to provide care management services to: (i) contain the cost of specified health care services/items overall with respect to all plans insured and/or administered by CHLIC, and/or (ii) improve adherence to evidence based guidelines designed to promote patient safety and efficient patient care.	**Specific vendor fees and care management program services are available upon request.**
ELIGIBILITY OVERPAYMENT RECOVERY FEES		
	Eligibility Overpayment Recovery Vendor Services. Identification and recovery of funds in situations where the overpayment is due to the late receipt of Member termination information. (This service is only provided with respect to Medical coverage).	**29% of recovery**
EXTERNAL REVIEW AND CONSULTATIVE REVIEW FEES		
	When a Member elects an External Review (as that term is defined in ERISA) of a benefit determination by an independent third party, the cost of a specific third party review is dependent on the nature and complexity of the issue on appeal. In highly complex, non-routine cases or cases related to new technology or experimental-investigational treatment, as part of the internal appeal process a panel of reviewers may be necessary. Third party review charges will be commensurate with the number of reviewers (usually only one is used), as well as their level of expertise and time required to complete the review.	**$500-$4,000 Review**
STRATEGIC ALLIANCES		
	CHLIC contracts directly or indirectly with other managed care entities and third party network vendors for access to their provider networks and discounts. These third parties charge either a network access fee, which is included in CHLIC's monthly charges, or a percentage of the savings realized on a claim by claim basis as a result of the application of their discounts. Charges based on percentage of savings may be paid from the Bank Account. Additional details regarding specific charges will be provided upon request.	**All Medical Products**

	OTHER VENDORS AND HEALTH CARE SERVICES PROVIDERS	
	Fixed per person per period and fee-for-service charges for various vendors and other providers/arrangers of health care services and/or supplies will be paid as claims for Plan Benefits. In addition, performance-based payments to Participating Providers will be charged to the Bank Account. Such payments will be at the payment rates then in effect, which may be amended from time to time. Additional details regarding charges and the identity of the vendor or provider of health care services will be made available upon request.	**All Products**
	NOTICE REGARDING PAYMENTS FROM THIRD PARTIES	
	Unless indicated otherwise in the Schedule of Financial Charges, CHLIC retains all payments it may receive from manufacturers of pharmaceutical products covered under the Plan. Information on the amount of such payments with respect to the Plan will be provided upon request.	**All Pharmacy Products**
	From time to time, CHLIC, directly or through its affiliates, arranges with third party parties (e.g., service vendors, provider network managers) to provide various services (e.g., cost-containment initiatives) in connection with the Plan. CHLIC and its affiliates may receive payments from such third parties to help defray CHLIC's expenses associated with the implementation and/or ongoing administration of these arrangements. CHLIC may also receive compensation from third-party vendors that Employer may retain based upon a referral from CHLIC or that Members may utilize following an introduction facilitated by CHLIC or an affiliate.	**All Products**
	COMPLIANCE ASSISTANCE	
	CHLIC shall provide the following services to assist Employer in meeting its compliance obligations under section 2715 of the Public Health Service Act as added by the Patient Protection and Affordable Care Act and applicable regulations with respect to the provision of the Summary of Benefits and Coverage ("SBC), translation notice and glossary. Applicable to all medical plans including HRA and FSA which are considered "group health plans" subject to the SBC requirements.	
1.	Preparation of SBC, translation notice. CHLIC will not be responsible for any changes that Employer makes to the SBC.	**No charge**
2.	Provide SBC, translation notices prepared by CHLIC to Employer electronically as well as any updates or material modifications.	**No charge**
3.	Include in SBC a summary of benefits administered by carve-out vendor if Employer or carve-out vendor provides CHLIC with necessary carve-out benefit information at least twelve (12) weeks prior to the date the SBCs are to be delivered to Employer.	**$500 for each benefit option under the Plan for which carve-out vendor benefits are included in SBC**

ADDITIONAL SERVICES		
Service	**Description**	**Charge**
Pharmacy Clinical Program	**Step Therapy Program** – a prior authorization/step therapy program that encourages cost-effective clinically appropriate drug utilization and reduces costs by creating a sequence of "steps" in the choice of medication used to treat some common medical conditions.	**Included in Pharmacy Administration Charge**
Clinical Program	**Cigna TheraCare® Program** – a targeted condition drug therapy management program that targets individuals using specialty medications for certain chronic conditions and helps them better understand their condition, medication side effects and importance of adherence.	**Included at No Additional Cost**
Your Health First	A proactive health education and improvement program for Members with a chronic condition. The program involves services that span across the Member's health needs. Behavioral coaching principles and evidence based medicine guidelines are utilized to optimize self-management skills and foster sustained health improvements. The program targets a chronic population at high risk for near term and future high cost medical expenses. Members are identified as having a chronic condition through a variety of sources which may include: claims data, referrals, and self-identification. A variety of resources is provided to those with a chronic condition, including access to online tools, personalized support, and targeted materials. The program includes the following components for those with a chronic condition: • Chronic condition-specific coaching • Pre- and post-discharge calls • Lifestyle management coaching: stress, weight management and tobacco cessation • Treatment decision support and coaching In order to continuously assess the effectiveness of the program and/or test new ideas to further engage Members around their health, a small sample of Members may be placed in a comparison group which for a defined period of time receives alternative services or is suppressed from receiving proactive outreach, such as engagement letters and/or calls. This could affect a few Members targeted for outreach during this limited time period.	**For OAP and HRA OAP Products: Included in Medical Access Fee**
Claim Litigation	Claim Litigation Services	**$3,500.00 Flat Annual Amount**
Claim and Appeals	CHLIC will administer an optional second level of claim appeals	**$0.94/employee/year Included in Medical Administration Charge**

Internet-Based Enrollment and Eligibility Management System	CHLIC, either directly or through its affiliate, Choicelinx®, will grant to Employer and Participants a nontransferable limited license to access Benefits Insight, CHLIC's Internet-Based Enrollment and Eligibility Management System for online enrollment and selection of benefits. Products and services are outlined in the Statement of Services provided to the Employer by Choicelinx®. More specific information about the products, services, charges, grant of license and applicable restrictions are available upon request.	**Included in Medical Administration Charge**
Client Fund		
Wellness Fund	For clinical/wellness/behavioral programs offered by CHLIC that are purchased, CHLIC will establish a Wellness Fund in the amount of $100,000.00. This fund will be used to defray the cost of CHLIC designated and arranged health and wellness improvement programs (e.g. biometric screenings, flu shots) for employees of Employer and to reward participation in these programs. The Wellness Fund is a one-time credit to be used from July 1, 2016 – June 30, 2017. Unused funds cannot be rolled over and CHLIC must pre-approve use of the Wellness Fund. The Wellness Fund shall be extinguished upon termination of this Agreement and any fund amount not used prior to termination of this Agreement shall only be available to Employer for the purpose of funding the cost of those reimbursable services provided prior to such termination.	

Exhibit B – Services

BANKING AND ADMINISTRATION		
Products excluding Health Savings Account		
1.	Furnishing CHLIC's standard Bank Account activity data reports to Employer as and when agreed upon. CHLIC's administration of the Plan does not include performing obligations, if any, under state escheat or unclaimed property laws. It is Employer's responsibility to determine the extent to which these laws may apply to the Plan and to comply with such laws.	**All Products**
2.	Report to Employer the claim payment information required in connection with Section 6041of the Internal Revenue Code.	**All Products**
3.	If Employer has elected, pursuant to section 63 of the New York Health Care Reform Act of 1996 (section 2807-t of the Public Health Law) ("the Act"), to pay the assessment on covered lives set forth in section 63 and has consented to the conditions set forth in section 63, CHLIC shall file such forms and pay such surcharge and assessment on covered lives on behalf of Employer through the Bank Account to the extent set forth in section 63. Such obligation shall end immediately upon Employer's failure to provide any information required by CHLIC to fulfill this obligation, the failure to comply with any requirement imposed upon Employer pursuant to the Act or the failure of Employer to properly fund the Bank Account. In addition, where permitted and agreed to by CHLIC, CHLIC will file applicable forms and pay on behalf of Employer and/or the Plan any assessment, surcharge, tax or other similar charge which is required to be made by Employer and/or the Plan based on covered lives and/or paid claims or otherwise in accordance with and as required by other applicable state and/or federal laws and regulations and the Bank Account will be charged for any such payments made by CHLIC.	**All Products**
CLAIM ADMINISTRATION		
Products excluding Health Savings Account		
1.	Calculate benefits, check and/or electronic payments disbursed from Employer's Bank Account. Bank Account payments will appear in Employer's standard Bank Account activity data reports.	**All Products**
2.	CHLIC's generic claim forms are made available to Employer for individuals eligible to enroll in the Plan.	**All Products**
3.	Investigate claims, as necessary, by CHLIC's Special Investigations Unit.	**All Products**
4.	Discuss claims, when appropriate, with providers of health services.	**All Products**
5.	Perform, based on CHLIC's book of business internal audits of plan benefit payments on a random sample basis.	**All Products**
6.	Claim control procedures reported annually in Statement on Standards for Attestation Engagements (SSAE) No. 16 Report (SAS70 successor report).	**All Products**
7.	Respond to Insurance Department complaints.	**All Products**

8.	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Products**
9.	Member Explanation of Benefit ("EOB") statements including, when applicable, notice of denied claims, denial reason(s) and appeal rights.	**All Products (excluding Pharmacy)**
10.	Verify enrollment and eligibility using Member information submitted by Employer and/or its authorized agent.	**All Products**
	Medical Only	
1.	CHLIC's generic enrollment form is made available to Employer for individuals eligible to enroll in the Plan.	**All Medical Products**
2.	CHLIC's standard ID card with toll-free telephone number are prepared and mailed directly to Members.	**All Medical Products**
3.	Administration of subrogation/conditional Claim Payment (terms described in Exhibit E).	**All Medical Products**
	Dental Only	
1.	CHLIC's generic enrollment form is made available to Employer for individuals eligible to enroll in the Plan.	**All Dental Products**
2.	CHLIC's generic ID cards are prepared and bulk shipped to the employer's address to distribute to their employees.	**All Dental Products**
3.	Standard Dental predetermination of benefits for dental procedures on a voluntary basis.	**All Dental Products**
4.	When elected, the Cigna Oral Health Integration Program® (OHIP) includes the provision of administrative services necessary to provide eligible Members with certain health conditions enhanced dental benefits. The program covers the following conditions: Maternity, Diabetes, Cardiovascular Programs, cerebrovascular disease (stroke), chronic kidney disease, organ transplants and head/neck cancer radiation, and is aimed at improving overall health by encouraging Members to obtain needed dental treatment by providing enhanced benefits. As appropriate, OHIP may be expanded to include new procedures, conditions and programs in the future.	**All Dental Products**
	Pharmacy Only	
1.	CHLIC's standard ID cards with toll-free telephone number are prepared and mailed directly to Members.	**All Pharmacy Products**
2.	Pharmacy claims are adjudicated typically on-line at time of service without access to information on other coverage, and therefore coordination of benefits (COB) for pharmacy claims does not occur. Claims for Plan Benefits will be paid regardless of coverage under another plan.	**All Pharmacy Products**
3.	CHLIC's standard drug utilization review services.	**All Pharmacy Products**
4.	CHLIC may receive and retain payments under contracts with drug manufacturers with respect to utilization covered under the Employer's medical benefit for the manufacturer's specialty drugs, which are drugs that typically are injected or infused and derived from living cells; target an underlying rare, chronic or costly condition; and/or require restricted access and/or close monitoring. If CHLIC enters into any such contracts, it does so on its own behalf, and not as agent of the Employer or the Plan.	**All Pharmacy Products**
	Health Care Flexible Spending Account and Dependent Care Flexible Spending Account Only	
1.	Providing generic enrollment forms and reimbursement request forms to Employer for use in connection with Health Care Flexible Spending Account ("FSA") and/or Dependent Care Flexible Spending Account ("DFSA") under which eligible employees (collectively "FSA Members") may elect to reduce their salary on a pre-tax basis up to the IRS maximum contribution allowed for deposit into a FSA and/or DFSA.	**FSA and DFSA Products**

2.	At the end of each reimbursement period of the Plan Year, CHLIC shall issue payments to the extent that funds remain in each FSA Member's account, for the amount that is determined by it to be proper under the Plan. At the end of the final reimbursement period of the Plan Year, CHLIC shall issue payments for any amount then due for those expenses that are determined by it to be proper under the Plan.	**FSA and DFSA Products**
3.	Allowable expenses for reimbursement under a DFSA include all allowable expenses incurred for the care of dependents pursuant to I.R.C. Sections 125 and 129.	**DFSA Product**
4.	Allowable expenses for reimbursement under a FSA include all allowable health-related expenses, pursuant to I.R.C. Sections 125 and 213 except where reimbursement under a FSA is prohibited.	**FSA Product**
5.	FSA Member account balances will remain open after conclusion of the Plan Year until September 30th (the "Run Out Period"), so that FSA Members can submit any remaining expenses incurred during the Plan Year. For employees enrolled in the FSA on the last day of the Plan Year, claims incurred in the first 2 ½ months following the end of the Plan Year can also be submitted during the Plan run out period and applied to Plan Year unused funds. Separate account balances will be maintained as per FSA Member's election for the new Plan Year.	**FSA and DFSA Products**
6.	Reimbursement requests of terminating FSA Members will continue to be processed for ninety (90) days following termination of FSA Membership for any expenses incurred prior to the FSA Membership termination date. In the case of a DFSA, reimbursement will be up to the balance in the DFSA and in the case of a FSA, reimbursement will be to the originally selected goal amount, minus prior reimbursements, regardless of whether this amount has been funded.	**FSA and DFSA Products**
7.	For FSA payments that are not made with a Debit Card but are a result of automatic claim forwarding ("AutoPay") of medical or dental claims from a medical or dental plan administered by CHLIC or Direct Submit Request For Reimbursement, an explanation of payment will be mailed to the FSA Member at their home address or, if elected, provided electronically. An explanation of payment is not issued for FSA payments that are issued to a pharmacy at the point of service as a result of automatic claim forwarding from the employee's pharmacy Plan.	**FSA Product**
8.	For DFSA payments made as a result of a Direct Submit Request For Reimbursement, an explanation of payment will be mailed to the DFSA Member at their home address or, if elected, provided electronically.	**DFSA Product**
9.	An 800 number directly linked to CHLIC's Member Services will be available for FSA Members' questions and status inquiries. This 800 number will be listed in the instructions on the reimbursement request form as well as having access to account information via Internet.	**FSA and DFSA Products**
10.	The Employer will identify through eligibility submission, FSA Members who elect to have medical and pharmacy claims processed but unpaid by CHLIC automatically submitted ("rolled over") to their FSA. Such rollover claims will be processed without additional submissions by the FSA Member and CHLIC shall be entitled to rely on the Employer's submission of the FSA Member's rollover election that the submitted expenses were properly incurred, not reimbursable from any other source and are eligible for payment under the regulations governing flexible spending accounts.	**FSA Product**

11.	When CHLIC takes over a FSA administration mid-Plan Year, CHLIC will provide administration services from the date CHLIC receives the FSA Plan information for claims incurred anytime during the Plan year.	**FSA and DFSA Product**
12.	For employees enrolled in a health care FSA plan with a debit card, a debit card will be issued to each FSA Member. (Employees enrolled in both a health care FSA plan with a debit card and a Health Reimbursement Account plan with a debit card will only receive one debit card covering both plans.) The card is pre-loaded with the FSA Member's annual Health Care FSA goal amount for the Plan Year. Plan Year FSA funds are available using the debit card for transactions actually processed during the Plan Year period. The card does not access funds from a prior Plan period unless the Plan has the extended claim period and the employee re-enrolls in the FSA for the subsequent period. If an employee terminates their FSA Plan or does not re-enroll in the FSA, the debit card will be de-activated and will not be available for use after the last day of the employee's FSA enrollment. The card is used by the FSA Member to access available FSA funds based upon the submitted goal amount less amount paid Plan Year to date from the fund. Since debits made with the card are not submitted by the card vendor to CHLIC in real-time but only on a daily basis, Employer agrees to fund all debits made by the FSA Member through the daily feed from the card vendor that indicates the FSA Member account is exhausted. The card is restricted to specific merchant types that are considered health care related. Although the card is limited to these types of merchants, the card does not limit specific items within these merchants. When the debit card is used, funds are automatically deducted from the FSA. FSA Members may be required to submit receipts to CHLIC to substantiate debit card expenditures. If appropriate substantiation is not received, the debit card will be suspended and no longer available for use.	**FSA Product**

Health Reimbursement Account (HRA), Healthy Awards (HA) and Healthy Future (HF) Only		
1.	Providing reimbursement request forms to Employer.	**HRA Products**
2.	Employer will make available specific funds to eligible employees enrolled in the HRA, HA and/or HF as applicable (**"Participating Members"**). At the end of each reimbursement period of the Plan Year, CHLIC shall issue payments to Participating Members (or their medical provider, if appropriate) to the extent of the maximum amount of payment allowed by Employer reduced by prior reimbursements for the same period of coverage, for the amount that is determined by it to be proper under the Plan.	**HRA Products**
3.	Allowable expenses for reimbursement under a HRA, HA and/or HF, as applicable, include all allowable health-related expenses, pursuant to I.R.C. Section 213 except where payment for any such products is prohibited. The Employer can further limit the allowable expenses as agreed to by the Employer during implementation.	**HRA Products**
4.	Account balances for Participating Members active until the end of the Plan Year will remain open after conclusion of the Plan Year for a period of 90 days, (the **"Run Out Period"**), so that such Participating Members can submit any remaining expenses incurred during the Plan Year.	**HRA Products**
5.	A Participating Member's request to terminate his/her enrollment in the HRA, HA, and/or HF, as applicable, will continue to be processed for 90 days following termination for any expenses incurred prior to his/her Participating Membership termination date up to the originally selected goal amount, minus prior reimbursements.	**HRA Products**
6.	For reimbursement payments that are made as a result of automatic claim forwarding ("AutoPay") of medical claims from a medical plan administered by CHLIC or Direct Submit Request For Reimbursement, an explanation of payment will be mailed to the Participating Member at their home address. An explanation of payment is not issued for payments that are issued to a pharmacy at the point of service as a result of AutoPay from the employee's pharmacy Plan or for any Debit Card transactions.	**HRA Products**
7.	Providing information on account balances and submitted claims to Participating Members calling the number on the ID card. In addition, Participating Members will have access to account information via Internet.	**HRA Products**
8.	When automatic claim forwarding ("AutoPay") is turned on, medical claims processed but unpaid by CHLIC will be automatically submitted for reimbursement from the HRA and/or HA Participating Member's HRA and/or HA account. Such "rollover" claims will be processed without additional submissions by the Participating Member.	**HRA Products**
9.	When CHLIC takes over HRA, HA and/or HF administration mid-Plan Year, CHLIC will provide administrative services from the date the Plan information is received.	**HRA Products**

10.	For employee enrolled in an HRA, HA and/or HF Plan with a debit card, a debit card will be issued to each HRA, HA and/or HF participating employee and spouse (if spouse is enrolled in the Plan). A debit card will also be issued upon employee request to other eligible dependents. (Employees enrolled in both a health care FSA Plan with a debit card and a Health Reimbursement Account Plan with a debit card will only receive one debit card covering both Plans.) The card is pre-loaded with the Participating Member's annual HRA, HA and/or HF goal amount for the Plan Year. Plan Year HRA, HA and/or HF funds are available using the debit card for transactions actually processed during the Plan Year period. The card will access funds from a prior Plan period when the employee re-enrolls in the HRA, HA and/or HF for the subsequent period and has remaining HRA, HA and/or HF funds that carry over to the new period, and the debit card was active for the prior plan period. If an employee terminates their HRA, HA and/or HF Plan or does not re-enroll in the HRA, HA and/or HF the debit card will be de-activated and will not be available for use after the last day of the employee's HRA, HA and/or HF enrollment. The card is used by the HRA, HA and/or HF Participating Member to access available HRA, HA and/or HF funds based upon the submitted goal amount plus any added incentive reward dollars (if applicable) less amount paid Plan Year to date from the fund. Since debits made with the card are not submitted by the card vendor to CHLIC in real-time but only on a daily basis, Employer agrees to fund all debits made by the Participating Member indicated through the daily feed from the card vendor, until the Participating Member's account is exhausted. The card is restricted to specific merchant types that are considered health care related based on service category elections. Although the card is limited to these types of merchants, the card does not limit specific items within these merchants, unless they are an inventory information approval system ("IIAS") merchant with The Special Interest Group for IIAS Standards ("SIGIS"). When the debit card is used, funds are automatically deducted from the HRA, HA and or HF. HRA, HA and/or HF Participating Members may be required to submit receipts to CHLIC to substantiate debit card expenditures. CHLIC will attempt to obtain the appropriate documentation from the participant via mail or email. If appropriate documentation to substantiate the transaction is not received, the debit card will be suspended and no longer available for use.	**HRA Products**
11.	Pharmacy claims: Eligible pharmacy expenses, under the HRA and/or HA that are processed but unpaid by CHLIC may be automatically submitted ("rolled over") to the Reimbursement Accounts Claim Office for reimbursement from the Participating Member's HRA, HA and/or HF account if the AutoPay option is enabled. Such rollover claims will be processed without additional submissions by the Participating Member. When pharmacy is covered and Cigna Pharmacy is the pharmacy vendor, the HRA and/or HA will automatically pay the pharmacy through the HRA and/or HA at the point of sale for all Participating Member obligations under the pharmacy Plan including deductibles, copays, and/or coinsurance obligations. A Participating Member will not receive an Explanation of Benefits for these payments.	**HRA Products**

	PLAN BOOKLET	
	Products excluding Health Savings Account	
	Prepare and make accessible Member benefit booklet drafts to Employer.	**All Products**
	UNDERWRITING SERVICES	
1.	5500 Schedule C reporting.	**All Products**
2.	5500 Schedule A or Annual Reconciliation Disclosure reporting (when applicable)	**All Products**
3.	CHLIC's standard Underwriting services: a) benefit design analysis-b) projected cost analysis.	**All Products**
	HIPAA INDIVIDUAL RIGHTS	
	Products excluding Health Savings Account	
	Handling of requests from Members for access to, amendment and accounting of protected health information, and requests for restrictions and alternative communications as required under federal HIPAA law and regulations, as set out in this Agreement and its Exhibits.	**All Products**
	COST CONTAINMENT	
1.	Maximum reimbursable charge determinations of non-Participating Provider charges for covered services.	**All Medical Products (with out-of-network benefits)**
2.	CHLIC's standard cost containment controls: Application of non-duplication and coordination of benefits rules and coordination with Medicare.	**All Medical Products**
3.	Delivery of information, as necessary, regarding standard application of non-duplication or coordination of benefits.	**All Medical and Dental Products**
4.	Review of medical bills in accordance with CHLIC's then current Medical Bill Review program.	**All Medical Products**
5.	Dental Cost Containment, a network of additional participating PPO providers that provide discounts for which CHLIC retains a portion of the savings generated.	**All Dental Products**
6.	Network Savings Program, a national vendor network that provides discounted rates when a Member accesses care through a Network Savings Program contracted provider.	**All Medical Products**
7.	Annual reporting of CHLIC's standard cost containment results upon Employer's request.	**All Medical and Dental Products**
8.	Pharmacy Vendor Recoveries.	**All Pharmacy Products**

	CUSTOMER REPORTING	
1.	Summary reports of medical, dental and pharmacy cost and utilization experience are available through Cigna's web site, CignaAccess.com.	**All Medical, Dental and Pharmacy Products**
2.	CHLIC's standard pharmacy utilization reports.	**Pharmacy Product Only**
3.	Claim Reporting: CHLIC will provide standard banking and financial report information based upon paid claim data. CHLIC will not provide information on incurred-but-not reported claims, projected claims, pre-certifications of coverage, case management information or information on a Member's prognosis or course of treatment. Stop Loss Reporting is an optional service provided at an additional fee to Employers who have stop loss through another entity other than CHLIC. CHLIC will provide its standard reporting only after the stop loss carrier and Employer have executed CHLIC's standard Hold Harmless/Confidentiality Agreement.	**All Medical Products**
4.	CHLIC's standard management and statistical reports for Employer.	**FSA and DFSA Products**
5.	CHLIC's standard Individual Summary Statements for applicable participating Members.	**FSA, DFSA and HRA Products**
6.	CHLIC's standard Health Reimbursement Account, Healthy Awards and/or Healthy Future activity report for Employer.	**HRA Products**
	COMPLIANCE	
	Employer directs CHLIC in administering the Health Care Flexible Spending Account, Healthy Awards, Healthy Futures and/or Health Reimbursement Account benefit to comply with COBRA as follows:	
1.	Each FSA Member who experiences a qualifying event and elects continuation of account coverage in accordance with COBRA will be maintained until the earlier of the end of the Plan Year, the exhaustion of the FSA balance or other termination of the FSA.	**FSA Product**
2.	FSA Members electing continuation of FSA coverage under COBRA will continue contributions at a rate not to exceed 102% of the applicable premium. The Employer may require after-tax contributions, or may allow the continuant to elect a lump-sum salary reduction in the amount required in contributions for the remainder of the coverage period.	**FSA Product**
3.	FSA Members who continue under COBRA and whose contributions have been made as required may submit Reimbursement Requests for themselves and any eligible dependents, for expenses incurred before or after the date of the qualifying event but prior to the end of the coverage period. Requests may be submitted until the earlier of the end of the Plan Year or the termination of the FSA, including any applicable Run-Out Period.	**FSA Product**
4.	The HRA, HA and/or HF of each HRA, HA and/or HF Participating Member who experiences a qualifying event and elects continuation of account coverage in accordance with COBRA will be maintained similar to the maintenance of an active employee. HF Participating Members that have not met their vesting requirements determined by the plan are not required to be offered COBRA for the HF.	**HRA Products**

	MEMBER EXTERNAL REVIEW PROGRAM	
	CHLIC contracts with three (3) independent review organizations that meet the Patient Protection and Affordable Care Act (PPACA) external review requirements. Members may appeal eligible claims to an external independent review organization which is selected by CHLIC on a random basis. If Employer has chosen not to participate in this program, the Employer may be responsible for making other arrangements to meet the Patient Protection and Affordable Care Act (PPACA) external review requirements.	**All Medical Products**
	MEDICAL MANAGEMENT SERVICES	
	CHLIC provides integrated medical management that includes (depending upon the terms of the Plan) the following core services.	
1.	Pre-Admission Certification and Continued Stay Review (PAC/CSR) services to certify coverage of acute and sub-acute inpatient admissions/stays or provides guidance to appropriate alternative settings. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products**
2.	Case Management and Retrospective Review of Inpatient Care, a service designed to provide assistance to a Member who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support.	**All Medical Products**
3.	Assist providers with resources and tools to enable them to develop long term treatment plans in the management of chronic or catastrophic cases.	**All Medical Products**
4.	The Cigna HealthCare Healthy Babies® Program is a one-time educational mailing which provides Participants with prenatal care education and resources to help them better manage their pregnancy. Other benefits of this program include the 24-Hour Health Information Line℠ and pregnancy information on myCigna.com.	**All Medical Products**
5.	HealthCare Cost and Quality tools on myCigna.com	**All Medical Products**
6.	A panel of physicians and other clinicians to assess the safety and effectiveness of new and emerging medical technologies. The panel meets monthly to review and update coverage policies.	**All Medical Products**
7.	The 24-Hour Health Information Line℠ is a service that provides twenty-four (24) hour toll free access to nurses, who provide answers to healthcare questions, recommend appropriate settings for care and assist Participants in locating physicians. It also includes access to an extensive audio library on a wide range of medical topics.	**All Medical Products**
8.	Cigna LifeSOURCE Transplant Network® contracts with over seven hundred fifty (750) transplant programs at more than one-hundred sixty (160) independent transplant facilities and provides access to solid organ and bone marrow/stem cell transplantation while improving cost containment and reducing financial risk.	**All Medical Products**
9.	A health education program that delivers mailings to Members with certain conditions.	**All Medical Products Except Comprehensive and Indemnity**
10.	If behavioral health services are provided/arranged by Cigna Behavioral Health (CBH), CBH provides utilization review and case management for both inpatient and outpatient, in-network behavioral health services.	**OAP and HRA OAP Products Only**

11.	Implement clinical quality measurements, track and validate performance and initiate continuous quality improvement.	**All Medical Products Except Comprehensive and Indemnity**
12.	Transition of care services to allow Members with defined conditions to continue treatment with non-Participating Providers after enrollment for continued uninterrupted care for a limited time.	**All Medical Products Except Comprehensive and Indemnity**
13.	Focused utilization management of outpatient procedures and identification of appropriate alternatives. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products with PHS Plus**
	NETWORK MANAGEMENT SERVICES	
	CHLIC, and/or its affiliates or contracted vendors shall:	
1.	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, fixed per person per period, per diem charges, incentive bonuses, case rates, withholds etc.). The amount and type of negotiated reimbursement may vary depending upon the type of plan. For example, a hospital may accept less for patients enrolled in certain types of plans than others; In addition, CHLIC may contract with Participating Providers and other parties for performance-based incentive payments to promote quality of care, patient safety and cost efficiency.	**All Medical and Pharmacy Products**
2.	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, fixed per person per period, per diem charges, incentive bonuses, case rates, withholds etc.). In addition, CHLIC may contract with Participating Providers and other parties for performance-based incentive payments to promote quality of care, patient safety and cost efficiency;	**All Dental Products**
3.	Credential and re-credential Participating Providers in accordance with CHLIC's credentialing requirements and ensure that third-party network vendors credential/re-credential Participating Providers in accordance with CHLIC's requirements;	**All Medical, Dental and Pharmacy Products**
4.	Monitor Participating Provider compliance with protocols and procedures for quality, Member satisfaction, and grievance resolution;	**All Medical, Dental and Pharmacy Products**
5.	Facilitate the identification of Participating Providers by Members; and	**All Medical, Dental and Pharmacy Products**
6.	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Medical, Dental and Pharmacy Products**

	BEHAVIORAL HEALTH	
	CHLIC has contracted with an affiliate, Cigna Behavioral Health ("CBH"), to provide or arrange for the provision of managed in-network behavioral health services, CBH is a Participating Provider, and is reimbursed primarily on a monthly fixed fee basis. This fixed fee for CBH services will be paid as claims and will appear in Employer's monthly reporting and on financial documents. Such payments will be at the relevant monthly rates then in effect. The monthly rates paid to CBH vary depending on geographic location of Members and on benefit design, and may be subject to change. The rates will be made available upon request. The fixed fee also includes lifestyle management programs, a cognitive behavioral modification program, a Complex Psychiatric Case Management program, and a Narcotics Therapy Management program. Behavioral claims from a client specific network are not included in the behavioral monthly fixed fee and will be paid from the Bank Account. In some states, payment for behavioral health services must be paid on a fee-for-service basis. In these states, fee-for-service payments for behavioral health services and the CBH administrative fee (including the lifestyle management programs, a cognitive behavioral modification program a Complex Psychiatric Case Management program and a Narcotics Therapy Management program) will be paid from the Bank Account as claims and will appear in Employer's monthly reporting.	**These services are included in the following products: OAP and HRA OAP**
	CIGNA STAFF MODEL HEALTHPLAN SERVICES	
	The Cigna HealthCare of Arizona, Inc. staff model ("Cigna Medical Group") is a Participating Provider located in metropolitan Phoenix, Arizona. Plan Members may at some time receive treatment from a Cigna Medical Group ("CMG") facility or provider even if they do not reside in Arizona (as when traveling). Members utilizing the IPA network will access certain specialty and/or ancillary services (including laboratory and urgent care services) through the CMG system. Lab services are not provided by CMG for Members in PPO or EPO plans. Except as provided below, for covered services provided to Members, CMG is paid at the rates in effect at the time of service (as may be revised from time to time). Representative rates for routinely performed services are attached. A complete copy of the rates is available on request under a mutually agreed nondisclosure agreement (NDA). If the Plan requires Members to select a primary care physician (PCP), Phoenix area Members who do not select a PCP during open enrollment are assigned to a CMG PCP. CMG is paid for PCP-required Plans at the rates in effect at the time of service. Primary care services rendered to Members in Open Access or LocalPlus Plans that do not provide for PCP assignment are paid at the rates then in effect, as described above. CMG may also receive applicable performance-based incentive payments for its participation in programs designed to improve quality, patient safety and affordability.	**All Medical Products**

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

EFFECTIVE AUGUST 1, 2014

(Applicable to all Open Access Plus Products)

Department	CPT Code	Description	OAP Rate
All Departments	99213	OFFICE VISIT,EST EXP PROB FOC	$65.80
Adult Medicine	99396	WELL EXAM, EST, 40-64 YEARS	$102.94
Pediatrics	99392	WELL EXAM, EST, 1-4 YEARS	$85.77
Gastroenterology	45378	COLONOSCOPY - Professional Fee only, at a facility	$257.75
Neurology	64615	CHEMODENERVATION OF MUSCLE MIGRAINE	$157.18
Ophthalmology	66984	REMOVE CATARACT, INSERT LEN- Professional Fee only, at a facility	$700.01
Podiatry	11721	DEBRIDEMENT NAIL SIX OR MORE	$39.95
Radiology	71020	CHEST X-RAY, PA & LAT	$30.38
Radiology	G0202 + 77052	SCREENING MAMMOGRAPHY DIGITAL	$141.02
Urology	52000	CYSTOSCOPY	$253.87
General Surgery	47562	LAPAROSCOPY;CHOLECYSTECTOMY- Professional Fee only, at a facility	$837.79
Optometry	92014	EYE EXAM & TREATMENT	$109.35
Lab	80053	COMPREHENSIVE METABOLIC PANEL	$14.87
Lab	80061	LIPID PANEL	$18.85
ASC (Ambulatory surgical center) / Endoscopy Suite	Grouper 2		$469.00
ASC (Ambulatory surgical center) / Endoscopy Suite	Grouper 8		$1,104.00

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

The Urgent Care case rate excluding radiology and laboratory services is $115.

CMG pharmacy rates (30-day supply):
Brand Name: AWP – 10.56% + $2.75 dispensing fee
Generic: AWP – 35% + $2.75 dispensing fee

APPENDIX A

Cigna Home Delivery Pharmacy Specialty Drug List

THIS SPECIALTY DRUG LIST IS CONFIDENTIAL, PROPRIETARY INFORMATION OF CIGNA. IT IS PROVIDED SOLELY FOR EMPLOYER'S PLAN ADMINISTRATION PURPOSES. RE-DISCLOSURE IS STRICTLY PROHIBITED EXCEPT AS OTHERWISE PROVIDED BY APPLICABLE LAW. CIGNA RESERVES ALL LEGAL RIGHTS AND REMEDIES TO ENFORCE THESE PROHIBITIONS ON USE AND DISCLOSURE.

Currently Marketed Specialty Drugs on this Specialty Drug List. The discounts in this Specialty Drug List are the discounts that will be adjudicated in Cigna's claim processing system for the drug indicated when dispensed by Cigna Home Delivery Pharmacy, subject to all of the following.

- Any or all of the discounts in this Specialty Drug List may be adjusted by Cigna in the event of a major change in market conditions affecting the pharmaceutical or pharmacy benefit management market, a drug shortage in the market, an issue involving the safety of the drug supply, or similar market situation.

- The discounts in this Specialty Drug List are based on the terms and design of the Pharmacy Benefit that Employer has adopted and disclosed to Cigna. Accordingly, if Employer fails to disclose to Cigna, for example, that it uses or intends to use a consumer-driven health plan, a major cost-sharing program, or a utilization management program promoting generic or OTC drugs over brand drugs, Cigna may adjust the discounts.

- The discounts in this Specialty Drug List shall not apply to compound drug claims, claims that process at U&C, and direct member reimbursement (DMR) claims.

- Any or all of the discounts in this Specialty Drug List may be adjusted by Cigna if (a) there are any significant changes in the composition of Cigna's pharmacy network or in Cigna's pharmacy network contract compensation rates, or the structure of the pharmacy stores/chains/vendors that are contracted with Cigna, including but not limited to disruption in the retail pharmacy delivery model, or bankruptcy of a chain pharmacy; or (b) there is a change in government laws or regulations which has a significant impact on pharmacy claim costs; or (c) any material manufacturer-rebate contracts with or for the benefit of Cigna are terminated or modified in whole or in part; or (d) there is any legal action or Law that materially affects or could materially affect the manner in which Cigna's rebate program is administered or an existing Law is interpreted so as to materially affect or potentially have a material effect on Cigna's administration of the Pharmacy Benefit; or (e) there is a material change in the Plan or the Plan's Pharmacy Benefit that is initiated by Employer which impacts Cigna's costs.

New-to-Market Specialty Products. Specialty Drug Claims that are for new-to-market drugs will have a minimum market-introduction guaranteed discount of 11.45% off the drug's AWP.

Cigna Home Delivery - Specialty Brand Discounts		
Condition	Brand Name	AWP Discount
ALS	RILUTEK	13.54%
AMD	EYLEA	11.45%
ANGIOEDEMA	FIRAZYR	11.45%
Anti-coagulant	INNOHEP	11.45%
ANTI-INFECTIVE	BETHKIS	11.45%
ANTI-INFECTIVE	CYTOGAM	11.45%
ANTI-INFECTIVE	CYTOVENE	11.45%
ANTI-INFECTIVE	FUZEON	11.45%
ANTI-INFECTIVE	KITABIS PAK	11.45%
ANTI-INFECTIVE	TOBI	11.45%
ANTI-INFECTIVE	TOBI PODHALER	13.54%
ANTI-INFECTIVE	VISTIDE	11.45%
Antithrombin III deficiency	ATRYN	11.45%
ASTHMA	XOLAIR	11.45%
CANCER - ANCILLARY/ADJUVANT	AKYNZEO	13.54%
CANCER - ANCILLARY/ADJUVANT	ALOXI	11.45%
CANCER - ANCILLARY/ADJUVANT	ANZEMET	11.45%
CANCER - ANCILLARY/ADJUVANT	ARANESP	11.45%
CANCER - ANCILLARY/ADJUVANT	COMETRIQ	13.54%
CANCER - ANCILLARY/ADJUVANT	ELIGARD	11.45%
CANCER - ANCILLARY/ADJUVANT	ELITEK	11.45%
CANCER - ANCILLARY/ADJUVANT	EMEND	13.54%
CANCER - ANCILLARY/ADJUVANT	EPOGEN	11.45%
CANCER - ANCILLARY/ADJUVANT	ETHYOL	11.45%
CANCER - ANCILLARY/ADJUVANT	FIRMAGON	11.45%
CANCER - ANCILLARY/ADJUVANT	FUSILEV	11.45%
CANCER - ANCILLARY/ADJUVANT	GRANIX	11.45%
CANCER - ANCILLARY/ADJUVANT	LEUCOVORIN CALCIUM	13.54%
CANCER - ANCILLARY/ADJUVANT	LEUKINE	11.45%
CANCER - ANCILLARY/ADJUVANT	LUPANETA	11.45%
CANCER - ANCILLARY/ADJUVANT	LUPRON DEPOT	11.45%
CANCER - ANCILLARY/ADJUVANT	LUPRON DEPOT-PED	11.45%
CANCER - ANCILLARY/ADJUVANT	MESNEX	11.45%
CANCER - ANCILLARY/ADJUVANT	NEULASTA	13.00%
CANCER - ANCILLARY/ADJUVANT	NEUMEGA	11.45%
CANCER - ANCILLARY/ADJUVANT	NEUPOGEN	11.45%
CANCER - ANCILLARY/ADJUVANT	PROCRIT	11.45%

CANCER - ANCILLARY/ADJUVANT	SUPPRELIN LA	11.45%
CANCER - ANCILLARY/ADJUVANT	VANTAS	11.45%
CANCER - ANCILLARY/ADJUVANT	VORAXAZE	11.45%
CANCER - ANCILLARY/ADJUVANT	ZOLADEX	11.45%
CANCER - CHEMOTHERAPY	ABRAXANE	11.45%
CANCER - CHEMOTHERAPY	ADCETRIS	15.00%
CANCER - CHEMOTHERAPY	ADRIAMYCIN	11.45%
CANCER - CHEMOTHERAPY	ADRIAMYCIN RDF	11.45%
CANCER - CHEMOTHERAPY	AFINITOR	13.54%
CANCER - CHEMOTHERAPY	AFINITOR DISPERZ	13.54%
CANCER - CHEMOTHERAPY	AGRYLIN	13.54%
CANCER - CHEMOTHERAPY	ALIMTA	11.45%
CANCER - CHEMOTHERAPY	ALKERAN	11.45%
CANCER - CHEMOTHERAPY	ARRANON	11.45%
CANCER - CHEMOTHERAPY	ARZERRA	11.45%
CANCER - CHEMOTHERAPY	AVASTIN	11.45%
CANCER - CHEMOTHERAPY	BELEODAQ	11.45%
CANCER - CHEMOTHERAPY	BEXXAR	11.45%
CANCER - CHEMOTHERAPY	BICNU	11.45%
CANCER - CHEMOTHERAPY	BLINCYTO	11.45%
CANCER - CHEMOTHERAPY	BOSULIF	13.54%
CANCER - CHEMOTHERAPY	BUSULFEX	11.45%
CANCER - CHEMOTHERAPY	CAMPATH	11.45%
CANCER - CHEMOTHERAPY	CAMPTOSAR	11.45%
CANCER - CHEMOTHERAPY	CAPRELSA	11.45%
CANCER - CHEMOTHERAPY	CASODEX	13.54%
CANCER - CHEMOTHERAPY	CERUBIDINE	11.45%
CANCER - CHEMOTHERAPY	CLOLAR	11.45%
CANCER - CHEMOTHERAPY	COSMEGEN	11.45%
CANCER - CHEMOTHERAPY	DACOGEN	11.45%
CANCER - CHEMOTHERAPY	DAUNOXOME	11.45%
CANCER - CHEMOTHERAPY	DEPOCYT	11.45%
CANCER - CHEMOTHERAPY	DOCEFREZ	11.45%
CANCER - CHEMOTHERAPY	DOXIL	11.45%
CANCER - CHEMOTHERAPY	DOXORUBICIN HCL	16.66%
CANCER - CHEMOTHERAPY	DTIC-DOME IV	38.00%
CANCER - CHEMOTHERAPY	ELLENCE	11.45%
CANCER - CHEMOTHERAPY	ELOXATIN	11.45%
CANCER - CHEMOTHERAPY	ELSPAR	11.45%
CANCER - CHEMOTHERAPY	EMCYT	13.54%
CANCER - CHEMOTHERAPY	ERBITUX	11.45%

CANCER - CHEMOTHERAPY	ERIVEDGE	13.54%
CANCER - CHEMOTHERAPY	ERWINAZE	11.45%
CANCER - CHEMOTHERAPY	ETOPOPHOS	11.45%
CANCER - CHEMOTHERAPY	FASLODEX	11.45%
CANCER - CHEMOTHERAPY	FLUDARA	11.45%
CANCER - CHEMOTHERAPY	FOLOTYN	11.45%
CANCER - CHEMOTHERAPY	FUDR	11.45%
CANCER - CHEMOTHERAPY	GEMZAR	11.45%
CANCER - CHEMOTHERAPY	GLEEVEC	13.54%
CANCER - CHEMOTHERAPY	GLIADEL	12.92%
CANCER - CHEMOTHERAPY	GLIADEL WAFER	12.91%
CANCER - CHEMOTHERAPY	HALAVEN	11.45%
CANCER - CHEMOTHERAPY	HERCEPTIN	11.45%
CANCER - CHEMOTHERAPY	HEXALEN	13.54%
CANCER - CHEMOTHERAPY	HYCAMTIN	13.54%
CANCER - CHEMOTHERAPY	IBRANCE	13.54%
CANCER - CHEMOTHERAPY	ICLUSIG	13.54%
CANCER - CHEMOTHERAPY	IDAMYCIN PFS	11.45%
CANCER - CHEMOTHERAPY	IFEX	11.45%
CANCER - CHEMOTHERAPY	INLYTA	9.00%
CANCER - CHEMOTHERAPY	IRESSA	13.54%
CANCER - CHEMOTHERAPY	ISTODAX	11.45%
CANCER - CHEMOTHERAPY	IXEMPRA	11.45%
CANCER - CHEMOTHERAPY	JEVTANA	11.45%
CANCER - CHEMOTHERAPY	KADCYLA	11.45%
CANCER - CHEMOTHERAPY	KYPROLIS	11.45%
CANCER - CHEMOTHERAPY	LEUSTATIN	11.45%
CANCER - CHEMOTHERAPY	LYNPARZA	13.54%
CANCER - CHEMOTHERAPY	MARQIBO KIT	11.45%
CANCER - CHEMOTHERAPY	MATULANE	13.54%
CANCER - CHEMOTHERAPY	MEKINIST	13.54%
CANCER - CHEMOTHERAPY	MITHRACIN	11.45%
CANCER - CHEMOTHERAPY	MUSTARGEN	11.45%
CANCER - CHEMOTHERAPY	MYLOTARG	11.45%
CANCER - CHEMOTHERAPY	NAVELBINE	11.45%
CANCER - CHEMOTHERAPY	NEXAVAR	11.45%
CANCER - CHEMOTHERAPY	NEXAVIR	11.45%
CANCER - CHEMOTHERAPY	NIPENT	11.45%
CANCER - CHEMOTHERAPY	NOVANTRONE	11.45%
CANCER - CHEMOTHERAPY	OFORTA	17.00%
CANCER - CHEMOTHERAPY	ONCASPAR	11.45%

CANCER - CHEMOTHERAPY	ONTAK	11.45%
CANCER - CHEMOTHERAPY	OPDIVO	11.45%
CANCER - CHEMOTHERAPY	PANRETIN	11.45%
CANCER - CHEMOTHERAPY	PERJETA	11.45%
CANCER - CHEMOTHERAPY	POMALYST	13.54%
CANCER - CHEMOTHERAPY	PROLEUKIN	11.45%
CANCER - CHEMOTHERAPY	PROVENGE	11.45%
CANCER - CHEMOTHERAPY	REVLIMID	5.00%
CANCER - CHEMOTHERAPY	RITUXAN	11.45%
CANCER - CHEMOTHERAPY	SPRYCEL	13.54%
CANCER - CHEMOTHERAPY	STIVARGA	13.54%
CANCER - CHEMOTHERAPY	SUPPRELIN	11.45%
CANCER - CHEMOTHERAPY	SUTENT	13.54%
CANCER - CHEMOTHERAPY	SYLATRON	11.45%
CANCER - CHEMOTHERAPY	SYNRIBO	11.45%
CANCER - CHEMOTHERAPY	TAFINLAR	13.54%
CANCER - CHEMOTHERAPY	TARCEVA	13.54%
CANCER - CHEMOTHERAPY	TARGRETIN	13.54%
CANCER - CHEMOTHERAPY	TASIGNA	13.54%
CANCER - CHEMOTHERAPY	TAXOTERE	11.45%
CANCER - CHEMOTHERAPY	TEMODAR	13.54%
CANCER - CHEMOTHERAPY	THALOMID	13.54%
CANCER - CHEMOTHERAPY	TORISEL	11.45%
CANCER - CHEMOTHERAPY	TREANDA	11.45%
CANCER - CHEMOTHERAPY	TRELSTAR	11.45%
CANCER - CHEMOTHERAPY	TRISENOX	11.45%
CANCER - CHEMOTHERAPY	TYKERB	13.54%
CANCER - CHEMOTHERAPY	VALCHLOR	11.45%
CANCER - CHEMOTHERAPY	VALSTAR	11.45%
CANCER - CHEMOTHERAPY	VECTIBIX	11.45%
CANCER - CHEMOTHERAPY	VELCADE	11.45%
CANCER - CHEMOTHERAPY	VIDAZA	11.45%
CANCER - CHEMOTHERAPY	VOTRIENT	13.54%
CANCER - CHEMOTHERAPY	VUMON	11.45%
CANCER - CHEMOTHERAPY	XALKORI	11.45%
CANCER - CHEMOTHERAPY	XELODA	13.54%
CANCER - CHEMOTHERAPY	XTANDI	13.54%
CANCER - CHEMOTHERAPY	YERVOY	11.45%
CANCER - CHEMOTHERAPY	ZALTRAP	11.45%
CANCER - CHEMOTHERAPY	ZANOSAR	11.45%
CANCER - CHEMOTHERAPY	ZELBORAF	13.54%

CANCER - CHEMOTHERAPY	ZEVALIN	11.45%
CANCER - CHEMOTHERAPY	ZOLINZA	13.54%
CANCER - CHEMOTHERAPY	ZYDELIG	13.54%
CANCER - CHEMOTHERAPY	ZYTIGA	11.45%
CANCER-CEHMOTHERAPY	GILOTRIF	13.54%
CANCER-CHEMOTHERAPY	CYRAMZA	11.45%
CANCER-CHEMOTHERAPY	GAZYVA	11.45%
CANCER-CHEMOTHERAPY	IMBRUVICA	13.54%
CANCER-CHEMOTHERAPY	KEYTRUDA	11.45%
CANCER-CHEMOTHERAPY	ZYKADIA	11.45%
CHRONIC KIDNEY DISEASE	OMONTYS	11.45%
CYSTIC FIBROSIS	KALYDECO	13.54%
Cystinosis	CYSTAGON	13.54%
ENZYME DISORDER	ADAGEN	11.45%
ENZYME DISORDER	ALDURAZYME	12.00%
ENZYME DISORDER	ARALAST	11.45%
ENZYME DISORDER	ARALAST NP	13.54%
ENZYME DISORDER	CERDELGA	13.00%
ENZYME DISORDER	CEREDASE	12.00%
ENZYME DISORDER	CEREZYME	12.00%
ENZYME DISORDER	ELAPRASE	11.45%
ENZYME DISORDER	ELELYSO	11.45%
ENZYME DISORDER	FABRAZYME	12.00%
ENZYME DISORDER	GLASSIA	11.45%
ENZYME DISORDER	LUMIZYME	0.00%
ENZYME DISORDER	MYOZYME	12.00%
ENZYME DISORDER	NAGLAZYME	11.45%
ENZYME DISORDER	PROCYSBI DR	13.54%
ENZYME DISORDER	PROLASTIN	11.45%
ENZYME DISORDER	PROLASTIN C	11.45%
ENZYME DISORDER	SUCRAID	15.00%
ENZYME DISORDER	VIMIZIM	11.45%
ENZYME DISORDER	VPRIV	12.00%
ENZYME DISORDER	ZAVESCA	13.54%
ENZYME DISORDER	ZEMAIRA	11.45%
GROWTH HORMONE DEFICIENCY	EGRIFTA	11.45%
GROWTH HORMONE DEFICIENCY	GATTEX	11.45%
GROWTH HORMONE DEFICIENCY	GENOTROPIN	11.45%
GROWTH HORMONE DEFICIENCY	HUMATROPE	11.45%
GROWTH HORMONE DEFICIENCY	INCRELEX	0.00%
GROWTH HORMONE DEFICIENCY	NORDITROPIN	11.45%

GROWTH HORMONE DEFICIENCY	NORDITROPIN FLEXPRO	11.45%
GROWTH HORMONE DEFICIENCY	NORDITROPIN NORDIFLEX	11.45%
GROWTH HORMONE DEFICIENCY	NUTROPIN	11.45%
GROWTH HORMONE DEFICIENCY	NUTROPIN AQ	11.45%
GROWTH HORMONE DEFICIENCY	NUTROPIN AQ NUSPIN	11.45%
GROWTH HORMONE DEFICIENCY	OMNITROPE	11.45%
GROWTH HORMONE DEFICIENCY	SAIZEN	11.45%
GROWTH HORMONE DEFICIENCY	SEROSTIM	11.45%
GROWTH HORMONE DEFICIENCY	TEV-TROPIN	11.45%
GROWTH HORMONE DEFICIENCY	ZORBTIVE	11.45%
HEMOPHILIA	ADVATE	23.95%
HEMOPHILIA	ALPHANATE	32.00%
HEMOPHILIA	ALPHANINE SD	36.00%
HEMOPHILIA	ALPROLIX	11.00%
HEMOPHILIA	AMICAR	13.54%
HEMOPHILIA	BEBULIN	11.45%
HEMOPHILIA	BEBULIN VH IMMUNO	41.66%
HEMOPHILIA	BENEFIX	13.50%
HEMOPHILIA	CORIFACT	11.45%
HEMOPHILIA	CYKLOKAPRON	11.45%
HEMOPHILIA	ELOCTATE	25.00%
HEMOPHILIA	FEIBA NF	28.00%
HEMOPHILIA	FEIBA VH IMMUNO	28.00%
HEMOPHILIA	HELIXATE FS	31.25%
HEMOPHILIA	HEMOFIL M	40.00%
HEMOPHILIA	HUMATE-P	30.00%
HEMOPHILIA	KOATE-DVI	30.20%
HEMOPHILIA	KOGENATE FS	36.45%
HEMOPHILIA	LYSTEDA	11.45%
HEMOPHILIA	MONOCLATE-P	30.00%
HEMOPHILIA	MONONINE	24.00%
HEMOPHILIA	NOVOSEVEN	26.50%
HEMOPHILIA	NOVOSEVEN RT	26.50%
HEMOPHILIA	OBIZUR	31.25%
HEMOPHILIA	PROFILNINE SD	22.50%
HEMOPHILIA	RECOMBINATE	37.50%
HEMOPHILIA	RIXUBIS	30.00%
HEMOPHILIA	STIMATE	11.45%
HEMOPHILIA	THROMBATE III	11.45%
HEMOPHILIA	TRETTEN	11.45%
HEMOPHILIA	WILATE	25.00%

HEMOPHILIA	XYNTHA	30.00%
HEMOPHILIA	XYNTHA SOLOFUSE	30.00%
HEPATITIS B	BARACLUDE	13.54%
HEPATITIS B	HEPAGAM B	11.45%
HEPATITIS B	HEPSERA	13.54%
HEPATITIS B	HYPERHEP B S-D	11.45%
HEPATITIS B	NABI-HB	11.45%
HEPATITIS B	TYZEKA	13.54%
HEPATITIS C	ALFERON N	11.45%
HEPATITIS C	COPEGUS	13.54%
HEPATITIS C	HARVONI	13.54%
HEPATITIS C	INCIVEK	11.45%
HEPATITIS C	INFERGEN	11.45%
HEPATITIS C	INTRON	11.45%
HEPATITIS C	INTRON A	11.45%
HEPATITIS C	OLYSIO	13.54%
HEPATITIS C	PEGASYS	11.45%
HEPATITIS C	PEGASYS PROCLICK	11.45%
HEPATITIS C	PEGINTRON	11.45%
HEPATITIS C	PEGINTRON REDIPEN	11.45%
HEPATITIS C	REBETOL	13.54%
HEPATITIS C	RIBAPAK	13.54%
HEPATITIS C	RIBASPHERE	75.00%
HEPATITIS C	RIBATAB	13.54%
HEPATITIS C	SOVALDI	13.54%
HEPATITIS C	VICTRELIS	13.54%
HEPATITIS C	VIEKIRA	13.54%
HIV	APTIVUS	13.54%
HIV	ATRIPLA	13.54%
HIV	COMBIVIR	13.54%
HIV	COMPLERA	13.54%
HIV	CRIXIVAN	13.54%
HIV	EDURANT	13.54%
HIV	EMTRIVA	13.54%
HIV	EPIVIR	13.54%
HIV	EPIVIR HBV	13.54%
HIV	EPZICOM	13.54%
HIV	EVOTAZ	13.54%
HIV	INTELENCE	11.45%
HIV	INVIRASE	13.54%
HIV	ISENTRESS	13.54%

HIV	KALETRA	13.54%
HIV	LEXIVA	13.54%
HIV	NORVIR	13.54%
HIV	PREZCOBIX	13.54%
HIV	PREZISTA	13.54%
HIV	RESCRIPTOR	13.54%
HIV	RETROVIR	11.45%
HIV	REYATAZ	13.54%
HIV	SELZENTRY	13.54%
HIV	STRIBILD	13.54%
HIV	SUSTIVA	13.54%
HIV	TIVICAY	13.54%
HIV	TRIUMEQ	13.54%
HIV	TRIZIVIR	13.54%
HIV	TRUVADA	13.54%
HIV	TYBOST	13.54%
HIV	VIDEX	13.54%
HIV	VIDEX EC	13.54%
HIV	VIRACEPT	13.54%
HIV	VIRAMUNE	13.54%
HIV	VIRAMUNE XR	13.54%
HIV	VIREAD	13.54%
HIV	VITEKTA	13.54%
HIV	ZERIT	13.54%
HIV	ZIAGEN	13.54%
Homocystinuria	CYSTADANE	13.54%
IMIG	BAYGAM	11.45%
INFERTILITY	BRAVELLE	11.45%
INFERTILITY	CETROTIDE	13.00%
INFERTILITY	FERTINEX	17.00%
INFERTILITY	FOLLISTIM AQ	13.00%
INFERTILITY	GONAL-F	13.00%
INFERTILITY	GONAL-F RFF	13.00%
INFERTILITY	LUTREPULSE	11.45%
INFERTILITY	LUVERIS	11.45%
INFERTILITY	MENOPUR	13.00%
INFERTILITY	NOVAREL	13.00%
INFERTILITY	OVIDREL	13.00%
INFERTILITY	PREGNYL	13.00%
INFERTILITY	PROFASI	17.00%
INFERTILITY	REPRONEX	13.00%

IVIG	BIVIGAM	27.08%
IVIG	CARIMUNE NF NANOFILTERED	30.00%
IVIG	FLEBOGAMMA	27.08%
IVIG	FLEBOGAMMA DIF	20.00%
IVIG	GAMASTAN S-D	11.45%
IVIG	GAMMAGARD	37.00%
IVIG	GAMMAGARD LIQUID	33.00%
IVIG	GAMMAGARD S-D	37.00%
IVIG	GAMMAKED	32.50%
IVIG	GAMMAPLEX	27.08%
IVIG	GAMUNEX	27.08%
IVIG	GAMUNEX-C	24.00%
IVIG	HIZENTRA	28.00%
IVIG	HYQVIA	27.00%
IVIG	OCTAGAM	27.08%
IVIG	OCTAGAM	40.00%
IVIG	PRIVIGEN	35.00%
IVIG	VIVAGLOBIN	11.45%
MULTIPLE SCLEROSIS	AMPYRA	12.00%
MULTIPLE SCLEROSIS	AUBAGIO	12.00%
MULTIPLE SCLEROSIS	AVONEX	11.45%
MULTIPLE SCLEROSIS	BETASERON	11.45%
MULTIPLE SCLEROSIS	COPAXONE	11.45%
MULTIPLE SCLEROSIS	EXTAVIA	11.45%
MULTIPLE SCLEROSIS	GILENYA	11.89%
MULTIPLE SCLEROSIS	LEMTRADA	11.45%
MULTIPLE SCLEROSIS	PLEGRIDY	11.45%
MULTIPLE SCLEROSIS	REBIF	11.45%
MULTIPLE SCLEROSIS	REBIF REBIDOSE	11.46%
MULTIPLE SCLEROSIS	TECFIDERA	12.00%
MULTIPLE SCLEROSIS	TYSABRI	15.00%
MYELOFIBROSIS	JAKAFI	13.54%
OTHER	ACTHAR H.P.	8.55%
OTHER	ACTHREL	11.45%
OTHER	ACTIMMUNE	11.45%
OTHER	ARCALYST	11.45%
OTHER	AREDIA	13.54%
OTHER	ARIXTRA	11.45%
OTHER	BERINERT	11.45%
OTHER	BONIVA	11.45%
OTHER	BOTOX	11.45%

OTHER	BOTOX COSMETIC	11.45%
OTHER	CINRYZE	11.45%
OTHER	DDAVP	11.45%
OTHER	DYSPORT	11.45%
OTHER	ESBRIET	13.54%
OTHER	EXJADE	13.54%
OTHER	FORTEO	11.45%
OTHER	FRAGMIN	11.45%
OTHER	HP ACTHAR	8.55%
OTHER	HYALGAN	11.45%
OTHER	HYLENEX	0.00%
OTHER	HYPERRAB S-D	11.45%
OTHER	ILARIS	11.45%
OTHER	ILUVIEN	11.45%
OTHER	IMOGAM RABIES-HT	11.45%
OTHER	IPRIVASK	11.45%
OTHER	JETREA	11.45%
OTHER	JUXTAPID	13.54%
OTHER	KALBITOR	11.45%
OTHER	KCENTRA	11.45%
OTHER	KCENTRA KIT	11.45%
OTHER	KRYSTEXXA	11.45%
OTHER	KUVAN	11.45%
OTHER	KYNAMRO	11.45%
OTHER	LOVENOX	11.45%
OTHER	LUCENTIS	11.45%
OTHER	MACUGEN	11.45%
OTHER	MIRCERA	11.45%
OTHER	MONOVISC	11.45%
OTHER	MOZOBIL	11.45%
OTHER	MYALEPT	11.45%
OTHER	MYOBLOC	11.45%
OTHER	NATRECOR	11.45%
Other	NORTHERA	13.54%
OTHER	NPLATE	11.45%
OTHER	OFEV	13.54%
OTHER	ORFADIN	13.54%
OTHER	ORTHOVISC	11.45%
OTHER	PHOTOFRIN	11.45%
OTHER	PRIALT	11.45%
OTHER	PROLIA	11.45%

OTHER	PROMACTA	13.54%
OTHER	PULMOZYME	11.45%
OTHER	RECLAST	11.45%
OTHER	REFLUDAN	11.45%
OTHER	RIASTAP	11.45%
OTHER	RUCONEST	11.45%
OTHER	SABRIL	13.54%
OTHER	SANDOSTATIN	11.45%
OTHER	SANDOSTATIN LAR	12.50%
OTHER	SENSIPAR	13.54%
OTHER	SIGNIFOR	11.45%
OTHER	SOLIRIS	12.83%
OTHER	SOMATULINE DEPOT	11.45%
OTHER	SOMAVERT	11.45%
OTHER	SYNAREL	11.45%
OTHER	SYNVISC	14.80%
OTHER	SYNVISC-ONE	14.80%
OTHER	THYROGEN	11.45%
OTHER	VIRAZOLE	11.45%
OTHER	VISUDYNE	11.45%
OTHER	VIVITROL	11.45%
OTHER	XENAZINE	13.54%
OTHER	XEOMIN	11.45%
OTHER	XGEVA	11.45%
OTHER	XIAFLEX	11.45%
OTHER	XYREM	13.54%
OTHER	ZEMPLAR	11.45%
OTHER	ZOMETA	11.45%
OTHER - Immunomodulator	AZASAN	13.54%
OTHER - Immunomodulator	IMURAN	13.54%
OTHER - Immunomodulator	OTREXUP	11.45%
OTHER - Immunomodulator	RASUVO	11.45%
OTHER - Immunomodulator	RHEUMATREX	13.54%
OTHER - Immunomodulator	THERACYS	11.45%
OTHER - Immunomodulator	TREXALL	13.54%
Parkinson's disease	APOKYN	11.45%
Protein C deficiency	CEPROTIN	11.45%
PSORIASIS	AMEVIVE	11.45%
PSORIASIS	COSENTYX	10.00%
PSORIASIS	STELARA	9.00%

PULMONARY ARTERIAL HYPERTENSION	ADCIRCA	13.54%
PULMONARY ARTERIAL HYPERTENSION	ADEMPAS	13.54%
PULMONARY ARTERIAL HYPERTENSION	FLOLAN	11.45%
PULMONARY ARTERIAL HYPERTENSION	LETAIRIS	11.45%
PULMONARY ARTERIAL HYPERTENSION	OPSUMIT	13.54%
PULMONARY ARTERIAL HYPERTENSION	ORENITRAM ER	13.54%
PULMONARY ARTERIAL HYPERTENSION	REMODULIN	11.45%
PULMONARY ARTERIAL HYPERTENSION	REVATIO	11.45%
PULMONARY ARTERIAL HYPERTENSION	TRACLEER	11.46%
PULMONARY ARTERIAL HYPERTENSION	TYVASO	11.45%
PULMONARY ARTERIAL HYPERTENSION	VELETRI	2.50%
PULMONARY ARTERIAL HYPERTENSION	VENTAVIS	6.25%
RA	KINERET	11.45%
RA	ORENCIA	11.45%
RA	XELJANZ	13.54%
RA/IBD	CIMZIA	11.45%
RA/JIA/PSOA/AS/PSORIASIS	ACTEMRA	11.45%
RA/JIA/PSOA/AS/PSORIASIS	ENBREL	11.45%
RA/JIA/PSOA/AS/PSORIASIS	ENTYVIO	11.45%
RA/JIA/PSOA/AS/PSORIASIS	OTEZLA	13.54%
RA/JIA/PSOA/AS/PSORIASIS/IBD	HUMIRA	11.45%
RA/PSOA/AS	SIMPONI ARIA	11.45%
RA/PSOA/AS	SIMPONI	11.45%
RA/PSOA/AS/PSORIASIS/IBD	REMICADE	14.50%
RESPIRATORY SYNCYTIAL VIRUS	SYNAGIS	12.50%
RHO(D) IMMUNE GLOBULIN	HYPERRHO	11.45%
RHO(D) IMMUNE GLOBULIN	HYPERRHO S-D	11.45%
RHO(D) IMMUNE GLOBULIN	MICRHOGAM	11.45%
RHO(D) IMMUNE GLOBULIN	MICRHOGAM PLUS	11.45%
RHO(D) IMMUNE GLOBULIN	RHOGAM	11.45%
RHO(D) IMMUNE GLOBULIN	RHOGAM PLUS	11.45%
RHO(D) IMMUNE GLOBULIN	RHOPHYLAC	11.45%
RHO(D) IMMUNE GLOBULIN	WINRHO SDF	11.45%
Systemic lupus erythematosus	BENLYSTA	11.45%
TRANSPLANT	ASTAGRAF XL	13.54%
TRANSPLANT	ATGAM	11.45%
TRANSPLANT	CELLCEPT	13.54%
TRANSPLANT	KEPIVANCE	11.45%
TRANSPLANT	MYFORTIC	13.54%
TRANSPLANT	NEORAL	13.54%
TRANSPLANT	NULOJIX	11.45%

TRANSPLANT	ORTHOCLONE OKT-3	11.45%
TRANSPLANT	PROGRAF	13.54%
TRANSPLANT	RAPAMUNE	13.54%
TRANSPLANT	SANDIMMUNE	11.45%
TRANSPLANT	SIMULECT	11.45%
TRANSPLANT	THYMOGLOBULIN	11.45%
TRANSPLANT	ZORTRESS	13.54%

Cigna Home Delivery and Retail - Specialty Generics Drug Discounts		
Condition	Brand Name	Average AWP Discount
ALS	RILUZOLE	83.02%
Anti-coagulant	ARGATROBAN	40.00%
ANTI-INFECTIVE	CIDOFOVIR	40.00%
ANTI-INFECTIVE	GANCICLOVIR	40.00%
ANTI-INFECTIVE	GANCICLOVIR SODIUM	40.00%
ANTI-INFECTIVE	TOBRAMYCIN	22.87%
CANCER - ANCILLARY/ADJUVANT	AMIFOSTINE	40.00%
CANCER - ANCILLARY/ADJUVANT	LEUCOVORIN CALCIUM	42.20%
CANCER - ANCILLARY/ADJUVANT	LEUPROLIDE	40.02%
CANCER - ANCILLARY/ADJUVANT	LEUPROLIDE ACETATE	40.02%
CANCER - ANCILLARY/ADJUVANT	MESNA	40.00%
CANCER - CHEMOTHERAPY	ADRIAMYCIN	15.00%
CANCER - CHEMOTHERAPY	ADRUCIL	19.49%
CANCER - CHEMOTHERAPY	ANAGRELIDE HCL	95.45%
CANCER - CHEMOTHERAPY	AZACITIDINE	16.71%
CANCER - CHEMOTHERAPY	BCG VACCINE (TICE STRAIN)	40.00%
CANCER - CHEMOTHERAPY	BICALUTAMIDE	93.48%
CANCER - CHEMOTHERAPY	BLEOMYCIN SULFATE	12.31%
CANCER - CHEMOTHERAPY	CAPECITABINE	20.49%
CANCER - CHEMOTHERAPY	CARBOPLATIN	11.00%
CANCER - CHEMOTHERAPY	CISPLATIN	1.04%
CANCER - CHEMOTHERAPY	CLADRIBINE	16.66%
CANCER - CHEMOTHERAPY	CYCLOPHOSPHAMIDE	42.57%
CANCER - CHEMOTHERAPY	CYTARABINE	27.51%
CANCER - CHEMOTHERAPY	DACARBAZINE	40.00%
CANCER - CHEMOTHERAPY	DACTINOMYCIN	40.00%
CANCER - CHEMOTHERAPY	DAUNORUBICIN	40.00%
CANCER - CHEMOTHERAPY	DAUNORUBICIN HCL	40.00%
CANCER - CHEMOTHERAPY	DECITABINE	21.00%

CANCER - CHEMOTHERAPY	DOCETAXEL	30.50%
CANCER - CHEMOTHERAPY	DOXORUBICIN	15.00%
CANCER - CHEMOTHERAPY	DOXORUBICIN HCL	15.00%
CANCER - CHEMOTHERAPY	EPIRUBICIN	40.00%
CANCER - CHEMOTHERAPY	EPIRUBICIN HCL	40.00%
CANCER - CHEMOTHERAPY	ETOPOSIDE	15.13%
CANCER - CHEMOTHERAPY	FLOXURIDINE	40.00%
CANCER - CHEMOTHERAPY	FLUDARABINE	40.00%
CANCER - CHEMOTHERAPY	FLUDARABINE PHOSPHATE	40.00%
CANCER - CHEMOTHERAPY	FLUOROURACIL	19.09%
CANCER - CHEMOTHERAPY	FLUTAMIDE	41.33%
CANCER - CHEMOTHERAPY	GEMCITABINE	40.00%
CANCER - CHEMOTHERAPY	GEMCITABINE HCL	40.00%
CANCER - CHEMOTHERAPY	IDARUBICIN HCL	40.00%
CANCER - CHEMOTHERAPY	IFOSFAMIDE	40.00%
CANCER - CHEMOTHERAPY	IFOSFAMIDE-MESNA	40.00%
CANCER - CHEMOTHERAPY	IRINOTECAN	21.00%
CANCER - CHEMOTHERAPY	IRINOTECAN HCL	21.00%
CANCER - CHEMOTHERAPY	LIPODOX	21.00%
CANCER - CHEMOTHERAPY	LIPODOX 50	21.00%
CANCER - CHEMOTHERAPY	MELPHALAN HCL	40.00%
CANCER - CHEMOTHERAPY	METHOTREXATE	49.93%
CANCER - CHEMOTHERAPY	MITOMYCIN	40.00%
CANCER - CHEMOTHERAPY	MITOXANTRONE HCL	40.00%
CANCER - CHEMOTHERAPY	ONXOL	11.00%
CANCER - CHEMOTHERAPY	OXALIPLATIN	16.66%
CANCER - CHEMOTHERAPY	PACLITAXEL	11.00%
CANCER - CHEMOTHERAPY	PENTOSTATIN	40.00%
CANCER - CHEMOTHERAPY	TEMOZOLOMIDE	25.71%
CANCER - CHEMOTHERAPY	TENIPOSIDE	40.00%
CANCER - CHEMOTHERAPY	THIOTEPA	40.00%
CANCER - CHEMOTHERAPY	TOPOSAR	30.55%
CANCER - CHEMOTHERAPY	TOPOTECAN	40.00%
CANCER - CHEMOTHERAPY	TOPOTECAN HCL	40.00%
CANCER - CHEMOTHERAPY	VANDETANIB	40.00%
CANCER - CHEMOTHERAPY	VINBLASTINE SULFATE	40.00%
CANCER - CHEMOTHERAPY	VINCASAR PFS	11.98%
CANCER - CHEMOTHERAPY	VINCRISTINE	24.83%
CANCER - CHEMOTHERAPY	VINCRISTINE SULFATE	24.83%
CANCER - CHEMOTHERAPY	VINORELBINE	40.00%
CANCER - CHEMOTHERAPY	VINORELBINE TARTRATE	40.00%

HEMOPHILIA	AMINOCAPROIC ACID	48.02%
HEMOPHILIA	TRANEXAMIC ACID	21.00%
HEPATITIS B	ADEFOVIR DIPIVOXIL	16.00%
HEPATITIS B	ENTECAVIR	40.00%
HEPATITIS C	MODERIBA	82.15%
HEPATITIS C	RIBAPAK	20.56%
HEPATITIS C	RIBASPHERE	90.11%
HEPATITIS C	RIBAVIRIN	90.11%
HIV	ABACAVIR	16.00%
HIV	ABACAVIR-LAMIVUDINE-ZIDOV	16.00%
HIV	DIDANOSINE	16.00%
HIV	LAMIVUDINE	16.00%
HIV	LAMIVUDINE-ZIDOVUDIN	26.64%
HIV	LAMIVUDINE-ZIDOVUDINE	26.64%
HIV	NEVIRAPINE	62.81%
HIV	NEVIRAPINE ER	16.00%
HIV	STAVUDINE	64.64%
HIV	ZIDOVUDINE	74.96%
INFERTILITY	CHORIONIC GONADOTROPIN	16.00%
INFERTILITY	GANIRELIX ACETATE	13.01%
IVIG	GAMMAPLEX	40.00%
IVIG	PRIVIGEN	40.00%
MULTIPLE SCLEROSIS	EXTAVIA	11.45%
OTHER	DESMOPRESSIN	15.00%
OTHER	DESMOPRESSIN ACETATE	15.00%
OTHER	ENOXAPARIN	53.00%
OTHER	ENOXAPARIN SODIUM	52.86%
OTHER	EUFLEXXA	17.00%
OTHER	FONDAPARINUX	16.17%
OTHER	FONDAPARINUX SODIUM	16.17%
OTHER	GEL-ONE	17.00%
OTHER	IBANDRONATE	40.00%
OTHER	OCTREOTIDE ACET	36.48%
OTHER	OCTREOTIDE ACETATE	34.15%
OTHER	PAMIDRONATE	40.00%
OTHER	PAMIDRONATE DISOD	40.00%
OTHER	PAMIDRONATE DISODIUM	40.00%
OTHER	PARICALCITOL	16.00%
OTHER	PROVISC	19.09%
OTHER	SUPARTZ	17.00%
OTHER	ZOLEDRONIC ACID	17.27%

OTHER - Immunomodulator	AZATHIOPRINE	58.29%
OTHER - Immunomodulator	METHOTREXATE	49.93%
OTHER - Immunomodulator	METHOTREXATE SODIUM	29.84%
PULMONARY ARTERIAL HYPERTENSION	EPOPROSTENOL SODIUM	40.00%
PULMONARY ARTERIAL HYPERTENSION	SILDENAFIL	90.98%
TRANSPLANT	CYCLOSPORINE	41.63%
TRANSPLANT	CYCLOSPORINE MODIFIED	16.00%
TRANSPLANT	GENGRAF	16.79%
TRANSPLANT	HECORIA	33.46%
TRANSPLANT	MYCOPHENOLATE	88.23%
TRANSPLANT	MYCOPHENOLATE MOFETIL	88.24%
TRANSPLANT	MYCOPHENOLIC ACID	16.00%
TRANSPLANT	MYCOPHENOLIC ACID DR	16.00%
TRANSPLANT	SIROLIMUS	19.58%
TRANSPLANT	TACROLIMUS	33.48%

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')

Attached to and made part of Group Policy No. 3338881

It is hereby agreed that said policy is amended as follows:

- Page CSL-SCH headed COVERAGE INFORMATION is deleted and the attached Pages headed COVERAGE INFORMATION is substituted therefore.

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')
Schedule of Insurance

Coverage Information

Policyholder:	City of Santa Fe
Policy Number:	3338881
Effective Date of this Amendment:	July 01, 2016
Issue Date:	July 30, 2016
Next Renewal Date:	July 01, 2017
State or other Jurisdiction of Issue:	New Mexico

Notices

For the purpose of any notices required under this policy, such notices should be sent to the addresses shown below:

Cigna Health and Life Insurance Company
900 Cottage Grove Road, Hartford, CT 06152
Attn: Stop Loss Unit

City of Santa Fe
200 Lincoln Ave
Santa Fe, NM 87501
Attn: Vicki Gage
vlgage@santafenm.gov
505-995-6595

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')

Individual Stop Loss Coverage

Policy Year: July 01, 2016 to June 30, 2017

Covered Expenses: Claims that are Incurred between July 01, 2014 and June 30, 2017 and that Become Due between July 01, 2016 and June 30, 2017

Monthly Premium Rates:
For each covered employee $63.79

Individual Stop Loss Benefit Percentage Payable: 100%

Individual Stop Loss Limit: $250,000.00

The following Covered Persons have been identified as High Risk Individuals and shall be subject to the Individual Stop Loss Limit as specified below:

High Risk Individuals None

Benefit Plans Covered by Individual Stop Loss Coverage:

Claim Administrator	Product
Cigna	HRA Open Access Plus Plan
Cigna	Mental Health/Substance Abuse Disorders
Cigna	Open Access Plus Core Plan
Cigna	Open Access Plus Premium Plan
Cigna	Pharmacy Expense

Cigna's maximum liability per individual: Will be the individual maximum, if any, as set forth in the Benefit Plan less the Individual Stop Loss Limit

Additional exclusions from Individual Stop Loss coverage under this policy:

- Funds contributed by the company or an employee as part of a Health Reimbursement Account, Health Savings Account or Flexible Savings Account.
- All Retirees

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')

Aggregate Stop Loss Coverage

Policy Year: July 01, 2016 to June 30, 2017

Covered Expenses: Claims that are Incurred between July 01, 2014 and June 30, 2017 and that Become Due between July 01, 2016 and June 30, 2017

For purposes of Aggregate Stop Loss, amounts attributable to claim base state surcharges and/or the New York Covered Lives Assessment, as applicable, shall not be considered to be an excluded expenses of the Policyholder or Claim Administrator and as such shall be considered Covered Expenses.

Monthly Premium Rates:
For each covered employee $4.65

ASL Benefit Percentage Payable: 100%

Aggregate Individual Stop Loss Limit: $250,000.00

Benefit Plans Covered by Aggregate Stop Loss Coverage:

Claim Administrator	Product
Cigna	HRA Open Access Plus Plan
Cigna	Mental Health/Substance Abuse Disorders
Cigna	Open Access Plus Core Plan
Cigna	Open Access Plus Premium Plan
Cigna	Pharmacy Expense

Cigna's maximum liability for the Aggregate Stop Loss coverage: Unlimited for the Policy Year

Corridor Factor: 125%

Minimum Attachment Point: $22,894,575.00

Minimum Attachment Percentage: 100%

Minimum Attachment Lagged Month: Two Months prior to the Policy Year's first Policy Month

Lagged Month: Two Months Prior

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')

Monthly Attachment Factor (for each Covered Person):

Claim Administrator	Product	
Cigna	HRA Open Access Plus Plan	$1,099.11
Cigna	Open Access Plus Core Plan	$1,498.84
Cigna	Open Access Plus Premium Plan	$1,560.99

Additional exclusions from Aggregate Stop Loss Coverage:

- Funds, if any, contributed by the company or an employee as part of a Health Reimbursement Account, Health Savings Account or Flexible Savings Account.
- All Retirees

Payment of premium is considered acceptance of this policy and the terms within.

Victoria A. Sirica
Contractual Agreement Unit Manager
Cigna

Routing B2CAU
900 Cottage Grove Road
Hartford, CT 06152
Telephone 860.226.2785
Facsimile 860.730.3944
Victoria.Sirica@cigna.com

May 22, 2017

Victoria Gage
Assistant Director Human Resource Department
City of Santa Fe
200 Lincoln Avenue
Santa Fe, NM 87501

RE: Administrative Services Only Account No. 3338881

Dear Ms. Gage:

This letter will serve as an amendment to the Administrative Services Only Agreement between Cigna Health and Life Insurance Company ("CHLIC") and City of Santa Fe ("Employer"), effective July 1, 2015 (the "Agreement") and as amended on July 1, 2016.

Effective as of July 1, 2017, 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 2 "Claim Administration and Additional Services" of the Administrative Services Only Agreement is hereby amended to add provision e. to the existing language as follows:

e. As part of the Plan Benefits provided under this Agreement, CHLIC and Employer agree that CHLIC will provide the Pharmacy Benefit (as defined in Appendix A) services described in Appendix A and the Schedule of Financial Charges, if any (the "Pharmacy Benefit Provisions"). In the event of any conflict between the terms set forth in the Pharmacy Benefit Provisions and any other terms set forth in this Agreement, including Exhibits hereto, the Pharmacy Benefit Provisions shall control solely with respect to the Pharmacy Benefit services.

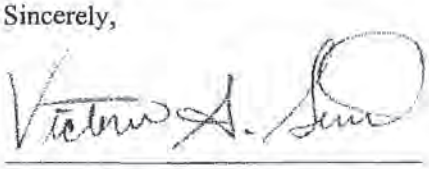
The Schedule of Financial Charges and Exhibit B, "Services" are hereby deleted in their entirety and replaced with the Schedule of Financial Charges and Exhibit B, "Services," as attached hereto.

Appendix A, "Cigna Home Delivery Pharmacy Specialty Drug List," of the Administrative Services Only Agreement is hereby deleted in its entirety and replaced with Appendix A, "Pharmacy Benefit Management Services", and Appendix B, "Cigna Home Delivery Pharmacy Specialty Drug List," as attached hereto.

"Cigna" is a registered service mark, and the "Tree of Life" logo is a service mark, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

The terms of the Administrative Services Only Agreement identified above, as mentioned herein, will be effective as of July 1, 2017. Please indicate your agreement to the amendment by signing the enclosed copy of this letter where indicated and returning it to me. Alternatively, this amendment shall become effective on the effective date indicated unless Employer notifies CHLIC either electronically or in writing (at the address indicated above) within sixty (60) days of the date of this letter that it does not accept all the terms of this amendment notwithstanding any provision to the contrary in the Administrative Services Only Agreement. In that case, CHLIC shall cooperate to negotiate mutually agreeable terms with Employer. Once agreement with respect to the terms of the amendment is reached, the amendment will apply retroactively to the effective date.

Sincerely,



Victoria A. Sirica
Its Contractual Agreement Unit Manager
Duly Authorized
Cigna Health and Life Insurance Company

Accepted by: **CITY OF SANTA FE**

By: _____

Name: _____

Title: _____

Executed this ____ day of _____, in the year _____.

Schedule of Financial Charges

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

MEDICAL/DENTAL ADMINISTRATION CHARGES		
Product	**Description**	**Charge**
Medical	• HRA Open Access Plus (OAP) with Care Management Preferred	**$44.70/employee/month**
Medical	• Open Access Plus (OAP) with Care Management Preferred	**$39.66/employee/month**
Dental	• Dental Preferred Provider Organization (DPPO)	**$3.52/employee/month**

MEDICAL/DENTAL NETWORK ACCESS FEE, UTILIZATION MANAGEMENT FEE AND OPTIONAL PROGRAM FEE		
Product	**Description**	**Charge**
Medical	• HRA OAP Access Fee	**$23.21/employee/month Included in Medical Administration Charge**
Medical	• OAP Access Fee	**$23.21/employee/month Included in Medical Administration Charge**
Dental	• DPPO Access Fee	**$0.82/employee/month Included in Dental Administration Charge**

CIGNA CHOICE FUND AND OTHER CONSUMER DIRECTED ACCOUNT ADMINISTRATION SERVICES AND CHARGES		
	Product	**Charge**
	• Cigna Choice Fund Health Reimbursement Account (HRA) Administration	**$5.04/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. • 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 • Support of Participants identified through predictive modeling with certain preference sensitive care conditions by supplying impartial evidence based medical information, to empower Participants' to understand the potential benefits/ disadvantages of a specific course of action and make more informed care decisions. • Answering health and medical related questions • Counseling Participants on prevention and the benefits of compliance with prescribed medications and treatments	**For HRA OAP Only: Included in Medical Access Fee**
	• Health Care Flexible Spending Account (FSA) Administration	**$5.79/employee/month**
	• Dependent Care Flexible Spending Account (DFSA) Administration	**$0.00/employee/month**
AMOUNTS OWED TO CHLIC		
Amounts paid by CHLIC with its own funds on behalf of Employer or the Plan with respect to charges for which Employer or the Plan is obligated to pay under this Agreement including Plan Benefits, Bank Account Payments (including fixed per person payments and pay-for-performance payments to Participating Providers), governmental taxes or assessments.		

CIGNA PHARMACY BENEFIT MANAGEMENT SERVICES CHARGES AND RELATED PROVISIONS
PHARMACY ADMINISTRATION FEE
• Cigna Pharmacy Product Administration Fee, only if applicable, is separate from the Medical Administration Charge shown above, but included on same billing line as the Medical Administration Charge for billing purposes only.
CHARGES FOR COVERED DRUGS
Drugs Dispensed by Cigna Home Delivery Pharmacy: CHLIC will administer Claims for Covered Drugs dispensed to Members by Cigna Home Delivery Pharmacy based on the following Actuarially Estimated charges, subject to the "PBM Pricing – Additional Provisions" section:
Brand Drug Claims: AWP minus an average discount of 21.00%. **Generic Drug Claims:** The Generic Drug's charge on a CHLIC MAC List which generates an average discount on Generic Drugs across those CHLIC clients in the aggregate using such MAC List of AWP minus 81.00%. **Specialty Drug Claims**: The Specialty Drug's charge discounted as shown in the Cigna Home Delivery Pharmacy Specialty Drug List, attached as Appendix B hereto. **Dispensing Fees for Both Brand Drug Claims and Generic Drug Claims:** An average Dispensing Fee of no more than $0.00.

Covered Drugs Dispensed by Retail Pharmacies in 30-day* supplies: CHLIC will administer Claims for 30-day supplies of Covered Drugs dispensed by a Retail Pharmacy based on the following Actuarially Estimated charges, subject to the "PBM Pricing – Additional Provisions" section: ***A 30-day supply includes any Covered Drug dispensed by a Retail Pharmacy in an amount less than an 83-day supply.**
Brand Drug Claims: The lesser of (i) AWP minus an average discount of 19.20%; or (ii) the Retail Pharmacy's U&C Charge. **Generic Drug Claims**: The lesser of: (i) the Generic Drug's charge on a CHLIC MAC List which generates an average discount on Generic Drugs across those CHLIC clients in the aggregate using such MAC List of AWP minus 78.00%; or (ii) the Retail Pharmacy's U&C Charge. **Specialty Generic Drug Claims:** The Specialty Generic Drug's charge discounted as shown in the Specialty Drug List, attached as Appendix B hereto. **Specialty Brand Drug Claims:** The lesser of (i) AWP minus an annual average aggregate discount of 11.50%; or (ii) the Retail Pharmacy's U&C Charge. **Dispensing Fees for Both Brand Drug Claims and Generic Drug Claims:** An average Dispensing Fee of no more than $1.40, except in the case of Claims adjudicated at the U&C Charge, for which no separate Dispensing Fee is charged.
Covered Drugs Dispensed by Retail Pharmacies in 90-day supplies:** CHLIC will administer Claims for 90-day supplies of Covered Drugs dispensed by a Retail Pharmacy based on the following Actuarially Estimated charges, subject to the "PBM Pricing – Additional Provisions" section: ****A 90-day supply includes any Covered Drug dispensed by a Retail Pharmacy in an amount equal to or greater than an 83-day supply.**
Brand Drug Claims: The lesser of (i) AWP minus an average discount of 21.00%; or (ii) the Retail Pharmacy's U&C Charge. **Generic Drug Claims**: The lesser of: (i) the Generic Drug's charge on a CHLIC MAC List that generates an average discount on Generic Drugs across those CHLIC clients in the aggregate using such MAC List of AWP minus 81.00%; or (ii) the Retail Pharmacy's U&C Charge. **Specialty Generic Drug Claims:** The Specialty Generic Drug's charge discounted as shown in the Specialty Drug List, attached as Appendix B hereto. **Specialty Brand Drug Claims:** The lesser of (i) AWP minus an annual average aggregate discount of 11.50%; or (ii) the Retail Pharmacy's U&C Charge. **Dispensing Fees for Both Brand Drug Claims and Generic Drug Claims:** An average Dispensing Fee of no more than $0.00, except in the case of Claims adjudicated at the U&C Charge, for which no separate Dispensing Fee is charged.

PBM PRICING – ADDITIONAL PROVISIONS
• Cigna Home Delivery Pharmacy's discounts are applied to the manufacturer average wholesale price (AWP) for the dispensed size (or to the AWP for the manufacturer-packaged quantity closest to the dispensed size, if there is no AWP for the dispensed size). • The amount paid by CHLIC to the Retail Pharmacy for Claims for Covered Drugs may or may not be equal to the amount charged to Employer, and CHLIC will absorb or retain any difference. • Unless specifically noted herein, the discounts to Employer for Covered Drugs set forth in this Agreement are not guaranteed to result in an average aggregate discount off the aggregate AWP of all such Covered Drugs. • CHLIC may, upon written notice to Employer, adjust any or all of the fees, Rebates (if any), discounts or guarantees (if any) in this Agreement to the extent reasonably necessary to preserve the economic value of this Agreement as it existed immediately prior to any of the following events or changes: (a) there are any significant changes in the composition of the CHLIC pharmacy network utilized by Employer hereunder or in such pharmacy network's contract compensation rates, or the structure of the pharmacy stores/chains/vendors that are contracted with CHLIC, including but not limited to disruption in the retail pharmacy delivery model, or bankruptcy of a chain pharmacy; or (b) there is a change in government laws or regulations which has a significant impact on pharmacy claim costs; or (c) any material manufacturer-rebate contracts with, or for the benefit of, CHLIC are terminated or modified in whole or in part; or (d) there is any legal action or law that materially affects or could materially affect the manner in which CHLIC's rebate program is administered or an existing law is interpreted so as to materially affect or potentially have a material effect on CHLIC's administration of the Plan; (e) a major change in market conditions affecting the pharmaceutical or pharmacy benefit management market, a drug shortage in the market, an issue involving the safety of the drug supply, or similar market event occurs; or (f) there is a material change in the Plan that is initiated by Employer (and which CHLIC agrees to administer) which impacts CHLIC's costs, or Employer fails to disclose a material feature of the Plan or the Plan's Pharmacy Benefit.

DRUG MANUFACTURER-PAYMENT SHARING
Subject to the caveats below, CHLIC will remit to Employer the following portion of Rebates that CHLIC collects with respect to utilization of Covered Drugs under the Plan's Pharmacy Benefit: $26.27 per Retail Pharmacy Brand Drug Claim dispensed in a 30-day* supply, $100.72 multiplied by the number of Retail Pharmacy Brand Drug Claim dispensed in a 90-day** supply and $128.01 per Cigna Home Delivery Pharmacy Brand Drug Claim.
Caveats: (1) Upon termination of this Agreement, CHLIC may use Rebates otherwise payable to Employer to offset payable Bank Account Payments or other payable fees or changes identified in this Agreement. (2) Should Employer terminate this Agreement before completion of the then-current Plan Year, no Rebates shall be due with respect to that Plan Year as payments of Rebates is conditioned on CHLIC exclusively administering the Pharmacy Benefits for the entire Plan Year. (3) For percentage-based sharing arrangements, payout amount may differ slightly from the stated percentage when payout occurs before manufacturers' final reconciliations and payments are made to CHLIC. (4) Rebates are not paid out on Run-Out Claims, on Claims for pharmaceutical products covered under the federal 340B drug pricing program, on pharmaceutical products or supplies covered under the Plan's medical benefit, or Compound Drugs. (5) CHLIC or its agent contracts with drug manufacturers on CHLIC's own behalf, and not as agent of the Employer or the Plan. Timing of Rebate Pay-Out: Remittance will be provided within ninety (90) days after the close of each applicable calendar year for the portion of such calendar year that coincides with the Plan Year.

FEES FOR PROCESSING RUN-OUT CLAIMS		
HRA OAP, OAP, DPPO	Run-Out Period of twelve (12) months	**No Additional Cost**
Pharmacy Product	Run-Out Period of three (3) months for all pharmacy claims	**No Additional Cost**
SUBROGATION		
	Subrogation/Conditional Claim Payment. Identification, investigation and recovery of claim payments involving other party liability or where another entity is responsible for payment (including by way of example but not by limitation automobile insurance, homeowner insurance, commercial property insurance, worker's compensation). (This service is only provided with respect to Medical coverage).	**5% of recovery plus litigation costs if counsel is retained and an appearance is filed on behalf of CHLIC or Employer in any litigation, or a lawsuit is filed on their behalf;** **29% of recovery if no counsel is retained and in all other instances, including cases where state law requires that employee benefit plans be named as party defendants or involuntary plaintiffs.**

CHLIC MEDICAL COST CONTAINMENT FEES

CHLIC administers the following programs to contain costs with respect to charges for health care service/supplies that are covered by the Plan. In administering these programs, CHLIC contracts with vendors to perform program related services. Specific vendor fees are available upon request subject to a mutually agreed upon non-disclosure agreement. CHLIC's charge for administering these programs is the percentage (indicated below) of either (1) the "net savings" (i.e. the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings, less the applicable vendor fee which generally ranges from 7-11% of the program savings) or (2) the "gross savings" (i.e. the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings; CHLIC pays the applicable vendor fee) or (3) the "recovery" (i.e. the amount recovered) as applicable.

For charges for covered services received from a non-Participating Provider (including emergency/urgent care services that are covered at the in-network benefit level), CHLIC may apply discounts available under agreements with third parties or through negotiation of the billed charges. These programs are identified below as the Network Savings Program, Supplemental Network, and Medical Bill Review (pre-payment). CHLIC charges the percentage shown for administering these programs. Applying these discounts may result in higher payments than if the maximum reimbursable charge is applied. Whereas application of the maximum reimbursable charge may result in the patient being balance billed for the entire unreimbursed amount, applying these discounts avoids balance billing and substantially reduces the patient's out-of pocket cost.

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

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

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

a. the amount of provider's billed charge not exceeding the greater of a CHLIC determined percentage of the Medicare allowable amount (the 80th percentile of the reasonable and customary charge if there is no Medicare allowable charge) or the amount required by state or federal, law (in the case of emergency room services) for charges subject to CHLIC's benefit enhancement policy (patient may be balance billed by the provider if the provider's charge exceeds such amount), or

b. the provider's billed charge.

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

1.	Network Savings Program	**29% of net savings**
2.	Supplemental Network	**29% of net savings**
3.	Medical Bill Review – (Pre-payment Cost Containment for Non-contracted claims):	
	Inpatient Hospital Bill Review	
	• Line Item Analysis	**Lesser of 5% of hospital bill or the savings achieved**
	• Professional Fee Negotiation	**29% of net savings**
	Outpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
	Physician/Professional Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
4.	Medical Bill Review – (Pre or Post-payment Cost Containment for Non-contracted and Contracted claims):	
	• Bill Audit	**29% of the savings/recovery achieved plus hospital fees or expenses passed through**
	Diagnosis Related Grouping (DRG) Validation/Audits and Recovery. An overpayment audit and recovery program in which CHLIC or its vendors review paid claim data to identify overpayments based on inaccurate DRG coding.	**29% of recovery plus any fees or expenses passed through by the hospital or regulatory agency**
	Medical Implant Device Audits	**29% of recovery**
5.	COB Vendor Recoveries [Exclusive of pharmacy programs where claims are adjudicated at time prescription is received.]	**29% of recovery**
6.	Secondary Vendor Recovery Program	**29% of recovery**
7.	Provider Credit Balance Recovery Program	**29% of recovery**

8.	High Cost Specialty Pharmaceutical Audits (this service is only provided with respect to Medical coverage)	**29% of recovery**
9.	Class Action Recoveries	**35% of recovery**
10.	Eligibility Overpayment Recovery Vendor Services. Identification and recovery of funds in situations where the overpayment is due to the late receipt of Member termination information. (This service is only provided with respect to Medical coverage).	**29% of recovery**
CHLIC PHARMACY COST CONTAINMENT FEES		
CHLIC administers the following programs to contain costs with respect to charges for health care service/supplies that are covered by the Plan. In administering these programs, CHLIC contracts with vendors to perform program related services. Specific vendor fees are available upon request subject to a mutually agreed upon non-disclosure agreement. CHLIC's charge for administering these programs is the percentage (indicated below) of the "recovery" (i.e. the amount recovered) as applicable. CHLIC pays the applicable vendor fee.		
1.	Pharmacy Vendor Recoveries. CHLIC performs periodic audits of contracted pharmacies in order to determine the accuracy of payments to the pharmacy(ies). CHLIC's recovery vendor collects and remits to CHLIC all overpayments to pharmacy(ies), and CHLIC remits to Employer's Bank Account the balance collected from the recovery vendor, less the recovery fee set forth herein.	**30% of recovery**
2.	Class Action Recoveries. CHLIC identifies, monitors and participates, on behalf of Employer, in class action recoveries in connection with suits against pharmaceutical manufacturers whereby recoveries are apportioned to class members on a pro rata basis. CHLIC collects and retains as a recovery fee set forth herein of any recovery (net of attorneys' fees) attributable to Employer's Plan.	**35% of recovery**

CHLIC DENTAL COST CONTAINMENT FEES		
Dental Cost Containment	CHLIC administers the following program to contain costs with respect to charges for dental services that are covered by the Plan. Applies to 2nd tier of participating DPPO network providers and includes: • Access to an additional network of DPPO dentists who provide care at a discounted rate. Lower out-of-pocket expenses for Members and additional claim savings for Employer when receiving covered services from these DPPO dentists. • CHLIC retains the percentage identified herein of Employer and/or Member gross savings for access and to cover the 2nd tier network administrative cost. • CHLIC calculates the percentage identified herein as fees charged on a pay-as-you save basis. If there is no savings, there is no fee charged to Employer. Gross savings are calculated by taking what the dental professional would have charged if not participating in the network minus the dentist's contracted fee. The dental cost containment fee is charged to Employer via the appropriate Electronic Funds Transfer (EFT) cycle as a percent of the savings assessed weekly against the Bank Account and would appear on Bank Account activity report(s) as Vendor Fee Reimbursement.	**25% of gross savings**
CARE MANAGEMENT/COST CONTAINMENT PROGRAM FEES		
	CHLIC arranges for third parties to provide care management services to: (i) contain the cost of specified health care services/items overall with respect to all plans insured and/or administered by CHLIC, and/or (ii) improve adherence to evidence based guidelines designed to promote patient safety and efficient patient care.	**Specific vendor fees and care management program services are available upon request.**
EXTERNAL REVIEW AND CONSULTATIVE REVIEW FEES		
	When a Member elects an External Review (as that term is defined in ERISA) of a benefit determination by an independent third party, the cost of a specific third party review is dependent on the nature and complexity of the issue on appeal. In highly complex, non-routine cases or cases related to new technology or experimental-investigational treatment, as part of the internal appeal process a panel of reviewers may be necessary. Third party review charges will be commensurate with the number of reviewers (usually only one is used), as well as their level of expertise and time required to complete the review.	**$500-$4,000 Review**

	STRATEGIC ALLIANCES	
	CHLIC contracts directly or indirectly with other managed care entities and third party network vendors for access to their provider networks and discounts. These third parties charge either a network access fee, which is included in CHLIC's monthly charges, or a percentage of the savings realized on a claim by claim basis as a result of the application of their discounts. Charges based on percentage of savings may be paid from the Bank Account. Additional details regarding specific charges will be provided upon request.	**All Medical Products**
	OTHER VENDORS AND HEALTH CARE SERVICES PROVIDERS	
	Fixed per person per period and fee-for-service charges for various vendors and other providers/arrangers of health care services and/or supplies will be paid as claims for Plan Benefits. In addition, performance-based payments to Participating Providers will be charged to the Bank Account. Such payments will be at the payment rates then in effect, which may be amended from time to time. Additional details regarding charges and the identity of the vendor or provider of health care services will be made available upon request.	**All Products**
	NOTICE REGARDING PAYMENTS FROM THIRD PARTIES	
	Unless indicated otherwise in the Agreement or the Schedule of Financial Charges, CHLIC retains all Rebates or other amounts it may receive from manufacturers of pharmaceutical products covered under the Plan Pharmacy Benefit. Information on the aggregate amount of such Rebates or other amounts with respect to the Plan Pharmacy Benefit will be provided upon request. This provision shall survive termination or expiration of the Agreement.	**All Pharmacy Products**
	CHLIC may receive and retain payments under contracts with pharmaceutical manufacturers with respect to Members' utilization of the manufacturer's specialty drugs covered under the Employer's Plan medical benefit. If CHLIC enters into any such contracts, it does so on its own behalf, and not as agent of the Employer or the Plan. CHLIC contracts with pharmaceutical manufacturers for any such remuneration on its own behalf and for its own benefit, and not on behalf of Employer or the Plan. Accordingly, CHLIC retains all right, title and interest to any and all such remuneration received from manufacturer; neither Employer, its Members, nor Employer's Plan retains any beneficial or proprietary interest in any such remuneration, which shall be considered part of the general assets of CHLIC. This provision shall survive termination or expiration of the Agreement.	**All Medical Products**

	From time to time, CHLIC, directly or through its affiliates, arranges with third parties (e.g., service vendors, provider network managers) to provide various services (e.g., cost-containment initiatives) in connection with the Plan. CHLIC and its affiliates may receive payments from such third parties to help defray CHLIC's expenses associated with the implementation and/or ongoing administration of these arrangements. CHLIC may also receive compensation from third-party vendors that Employer may retain based upon a referral from CHLIC or that Members may utilize following an introduction facilitated by CHLIC or an affiliate.	**All Products**
	COMPLIANCE ASSISTANCE	
	CHLIC shall provide the following services to assist Employer in meeting its compliance obligations under section 2715 of the Public Health Service Act as added by the Patient Protection and Affordable Care Act and applicable regulations with respect to the provision of the Summary of Benefits and Coverage ("SBC), translation notice and glossary. Applicable to all medical plans including HRA and FSA which are considered "group health plans" subject to the SBC requirements.	
1.	Preparation of SBC, translation notice. CHLIC will not be responsible for any changes that Employer makes to the SBC.	**No charge**
2.	Provide SBC, translation notices prepared by CHLIC to Employer electronically as well as any updates or material modifications.	**No charge**
3.	Include in SBC a summary of benefits administered by carve-out vendor if Employer or carve-out vendor provides CHLIC with necessary carve-out benefit information at least twelve (12) weeks prior to the date the SBCs are to be delivered to Employer.	**$500 for each benefit option under the Plan for which carve-out vendor benefits are included in SBC**

ADDITIONAL SERVICES		
Service	**Description**	**Charge**
Behavioral Health	Behavioral Care Advocacy provides behavioral health services in which claims are funded on a fee-for service basis. It includes focused utilization review and case management for inpatient, in-network behavioral health services. This payment arrangement is with respect to the CA/NC/VI Member population only.	**Included in Medical Access Fee**
Pharmacy Step Therapy Program	**Step Therapy Program** – a utilization management program under which, for some therapeutic classes, Members must try, or demonstrate contraindication or intolerance to, more cost-effective, clinically appropriate alternative drugs before CHLIC will approve coverage of non-preferred drugs in the same therapeutic class.	**Included in Pharmacy Administration Charge**
Clinical Program	**Cigna TheraCare® Program** – a targeted condition drug therapy management program that targets individuals using specialty medications for certain chronic conditions and helps them better understand their condition, medication side effects and importance of adherence.	**Included at No Additional Cost**
Your Health First	A proactive health education and improvement program for Members with a chronic condition. The program involves services that span across the Member's health needs. Behavioral coaching principles and evidence based medicine guidelines are utilized to optimize self-management skills and foster sustained health improvements. The program targets a chronic population at high risk for near term and future high cost medical expenses. Members are identified as having a chronic condition through a variety of sources which may include: claims data, referrals, and self-identification. A variety of resources is provided to those with a chronic condition, including access to online tools, personalized support, and targeted materials. The program includes the following components for those with a chronic condition: • Chronic condition-specific coaching • Pre- and post-discharge calls • Lifestyle management coaching: stress, weight management and tobacco cessation • Treatment decision support and coaching In order to continuously assess the effectiveness of the program and/or test new ideas to further engage Members around their health, a small sample of Members may be placed in a comparison group which for a defined period of time receives alternative services or is suppressed from receiving proactive outreach, such as engagement letters and/or calls. This could affect a few Members targeted for outreach during this limited time period.	**For HRA OAP, OAP Products: Included in Medical Access Fee**

Claim Litigation	Claim Litigation Services	**$3,500.00 Flat Annual Amount Included in Medical Administration Charge**
Claim and Appeals	CHLIC will administer an optional second level of claim appeals	**$0.94/employee/year Included in Medical Administration Charge**
Internet-Based Enrollment and Eligibility Management System	CHLIC, either directly or through its affiliate, Cigna Benefit Technology Solutions Inc., will grant to Employer and Participants a nontransferable limited license to access Benefits Insight, CHLIC's Internet-Based Enrollment and Eligibility Management System for online enrollment and selection of benefits. Products and services are outlined in the Statement of Services provided to the Employer by Cigna Benefit Technology Solutions Inc. More specific information about the products, services, charges, grant of license and applicable restrictions are available upon request.	**Included in Medical Administration Charge**

One Guide	One Guide is an enhanced level of personalized benefit service which offers Members proactive, personalized guidance and a simplified Member experience. The One Guide solution combines human interaction- through One Guide agents- with a robust digital tool - through the myCigna native mobile app - so Members have quick, convenient access to personal benefit information, and can engage the way they prefer. The system simplifies and strengthens the connection between Members, their benefit plan, and their overall health and well-being. One Guide proactively engages Members with clear ways to save money, stay healthy, and improve health outcomes that lead to a healthy lifestyle. One Guide offers: • education on health plan features, account balances and ways to maximize benefits and earn available incentives • guidance in finding the right doctor, lab, convenience care or pharmacy • 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.	**$3.50/employee/month Included in Medical Access Fee**
Client Fund		
Wellness Fund	For clinical/wellness/behavioral programs offered by CHLIC that are purchased, CHLIC will establish a Wellness Fund in the amount of $100,000.00. This fund will be used to defray the cost of CHLIC designated and arranged health and wellness improvement programs (e.g. biometric screenings, flu shots) for employees of Employer and to reward participation in these programs. The Wellness Fund is a one-time credit to be used from 07/01/2017 – 06/30/2018. Unused funds cannot be rolled over and CHLIC must pre-approve use of the Wellness Fund. The Wellness Fund shall be extinguished upon termination of this Agreement and any fund amount not used prior to termination of this Agreement shall only be available to Employer for the purpose of funding the cost of those reimbursable services provided prior to such termination.	

Exhibit B – Services

BANKING AND ADMINISTRATION		
Products excluding Health Savings Account		
1.	Furnishing CHLIC's standard Bank Account activity data reports to Employer as and when agreed upon. CHLIC's administration of the Plan does not include performing obligations, if any, under state escheat or unclaimed property laws. It is Employer's responsibility to determine the extent to which these laws may apply to the Plan and to comply with such laws.	**All Products**
2.	Report to Employer the claim payment information required in connection with Section 6041of the Internal Revenue Code.	**All Products**
3.	If Employer has elected, pursuant to section 63 of the New York Health Care Reform Act of 1996 (section 2807-t of the Public Health Law) ("the Act"), to pay the assessment on covered lives set forth in section 63 and has consented to the conditions set forth in section 63, CHLIC shall file such forms and pay such surcharge and assessment on covered lives on behalf of Employer through the Bank Account to the extent set forth in section 63. Such obligation shall end immediately upon Employer's failure to provide any information required by CHLIC to fulfill this obligation, the failure to comply with any requirement imposed upon Employer pursuant to the Act or the failure of Employer to properly fund the Bank Account. In addition, where permitted and agreed to by CHLIC, CHLIC will file applicable forms and pay on behalf of Employer and/or the Plan any assessment, surcharge, tax or other similar charge which is required to be made by Employer and/or the Plan based on covered lives and/or paid claims or otherwise in accordance with and as required by other applicable state and/or federal laws and regulations and the Bank Account will be charged for any such payments made by CHLIC.	**All Products**
CLAIM ADMINISTRATION		
Products excluding Health Savings Account		
1.	Calculate benefits, check and/or electronic payments disbursed from Employer's Bank Account. Bank Account payments will appear in Employer's standard Bank Account activity data reports.	**All Products**
2.	CHLIC's generic claim forms are made available to Employer for individuals eligible to enroll in the Plan.	**All Products**
3.	Investigate, pend, and/or recommend denial of claims in whole or in part, as necessary, by CHLIC's Special Investigations Unit.	**All Products**
4.	Discuss claims, when appropriate, with providers of health services.	**All Products**
5.	Perform, based on CHLIC's book of business internal audits of plan benefit payments on a random sample basis.	**All Products**
6.	Claim control procedures reported annually in Statement on Standards for Attestation Engagements (SSAE) No. 16 Report (SAS70 successor report).	**All Products**

7.	Respond to Insurance Department complaints.	**All Products**
8.	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Products**
9.	Member Explanation of Benefit ("EOB") statements including, when applicable, notice of denied claims, denial reason(s) and appeal rights.	**All Products (excluding Pharmacy)**
10.	Verify enrollment and eligibility using Member information submitted by Employer and/or its authorized agent.	**All Products**
	Medical Only	
1.	CHLIC's generic enrollment form is made available to Employer for individuals eligible to enroll in the Plan.	**All Medical Products**
2.	CHLIC's standard ID card with toll-free telephone number are prepared and mailed directly to Members.	**All Medical Products**
3.	Administration of subrogation/conditional Claim Payment (terms described in Exhibit E).	**All Medical Products**
	Dental Only	
1.	CHLIC's generic enrollment form is made available to Employer for individuals eligible to enroll in the Plan.	**All Dental Products**
2.	CHLIC's generic ID cards are prepared and bulk shipped to the employer's address to distribute to their employees.	**All Dental Products**
3.	Standard Dental predetermination of benefits for dental procedures on a voluntary basis.	**All Dental Products**
4.	When elected, the Cigna Oral Health Integration Program® (OHIP) includes the provision of administrative services necessary to provide eligible Members with certain health conditions enhanced dental benefits. The program covers the following conditions: Maternity, Diabetes, Cardiovascular Programs, cerebrovascular disease (stroke), chronic kidney disease, organ transplants and head/neck cancer radiation, and is aimed at improving overall health by encouraging Members to obtain needed dental treatment by providing enhanced benefits. As appropriate, OHIP may be expanded to include new procedures, conditions and programs in the future.	**All Dental Products**
	Health Reimbursement Account (HRA), Healthy Awards (HA) and Healthy Future (HF) Only	
1.	Providing reimbursement request forms to Employer.	**HRA Product**
2.	Employer will make available specific funds to eligible employees enrolled in the HRA, HA and/or HF as applicable (**"Participating Members"**). At the end of each reimbursement period of the Plan Year, CHLIC shall issue payments to Participating Members (or their medical provider, if appropriate) to the extent of the maximum amount of payment allowed by Employer reduced by prior reimbursements for the same period of coverage, for the amount that is determined by it to be proper under the Plan.	**HRA Product**
3.	Allowable expenses for reimbursement under a HRA, HA and/or HF, as applicable, include all allowable health-related expenses, pursuant to I.R.C. Section 213 except where payment for any such products is prohibited. The Employer can further limit the allowable expenses as agreed to by the Employer during implementation.	**HRA Product**
4.	Account balances for Participating Members active until the end of the Plan Year will remain open after conclusion of the Plan Year for a period of 90 daya, (the **"Run Out Period"**), so that such Participating Members can submit any remaining expenses incurred during the Plan Year.	**HRA Product**

5.	A Participating Member's request to terminate his/her enrollment in the HRA, HA, and/or HF, as applicable, will continue to be processed for 90 days following termination for any expenses incurred prior to his/her Participating Membership termination date up to the originally selected goal amount, minus prior reimbursements.	**HRA Product**
6.	For reimbursement payments that are made as a result of automatic claim forwarding ("AutoPay") of medical claims from a medical plan administered by CHLIC or Direct Submit Request For Reimbursement, an explanation of payment will be mailed to the Participating Member at their home address. An explanation of payment is not issued for payments that are issued to a pharmacy at the point of service as a result of AutoPay from the employee's pharmacy Plan or for any Debit Card transactions.	**HRA Product**
7.	Providing information on account balances and submitted claims to Participating Members calling the number on the ID card. In addition, Participating Members will have access to account information via Internet.	**HRA Product**
8.	When automatic claim forwarding ("AutoPay") is turned on, medical claims processed but unpaid by CHLIC will be automatically submitted for reimbursement from the HRA and/or HA Participating Member's HRA and/or HA account. Such "rollover" claims will be processed without additional submissions by the Participating Member.	**HRA Product**
9.	When CHLIC takes over HRA, HA and/or HF administration mid-Plan Year, CHLIC will provide administrative services from the date the Plan information is received.	**HRA Product**

10.	For employee enrolled in an HRA, HA and/or HF Plan with a debit card, a debit card will be issued to each HRA, HA and/or HF participating employee and spouse (if spouse is enrolled in the Plan). A debit card will also be issued upon employee request to other eligible dependents. (Employees enrolled in both a health care FSA Plan with a debit card and a Health Reimbursement Account Plan with a debit card will only receive one debit card covering both Plans.) The card is pre-loaded with the Participating Member's annual HRA, HA and/or HF goal amount for the Plan Year. Plan Year HRA, HA and/or HF funds are available using the debit card for transactions actually processed during the Plan Year period. The card will access funds from a prior Plan period when the employee re-enrolls in the HRA, HA and/or HF for the subsequent period and has remaining HRA, HA and/or HF funds that carry over to the new period, and the debit card was active for the prior plan period. If an employee terminates their HRA, HA and/or HF Plan or does not re-enroll in the HRA, HA and/or HF the debit card will be de-activated and will not be available for use after the last day of the employee's HRA, HA and/or HF enrollment. The card is used by the HRA, HA and/or HF Participating Member to access available HRA, HA and/or HF funds based upon the submitted goal amount plus any added incentive reward dollars (if applicable) less amount paid Plan Year to date from the fund. Since debits made with the card are not submitted by the card vendor to CHLIC in real-time but only on a daily basis, Employer agrees to fund all debits made by the Participating Member indicated through the daily feed from the card vendor, until the Participating Member's account is exhausted. The card is restricted to specific merchant types that are considered health care related based on service category elections. Although the card is limited to these types of merchants, the card does not limit specific items within these merchants, unless they are an inventory information approval system ("IIAS") merchant with The Special Interest Group for IIAS Standards ("SIGIS"). When the debit card is used, funds are automatically deducted from the HRA, HA and or HF. HRA, HA and/or HF Participating Members may be required to submit receipts to CHLIC to substantiate debit card expenditures. CHLIC will attempt to obtain the appropriate documentation from the participant via mail or email. If appropriate documentation to substantiate the transaction is not received, the debit card will be suspended and no longer available for use.	**HRA Product**
11.	Pharmacy claims: Eligible pharmacy expenses, under the HRA and/or HA that are processed but unpaid by CHLIC may be automatically submitted ("rolled over") to the Reimbursement Accounts Claim Office for reimbursement from the Participating Member's HRA, HA and/or HF account if the AutoPay option is enabled. Such rollover claims will be processed without additional submissions by the Participating Member. When pharmacy is covered and Cigna Pharmacy is the pharmacy vendor, the HRA and/or HA will automatically pay the pharmacy through the HRA and/or HA at the point of sale for all Participating Member obligations under the pharmacy Plan including deductibles, copays, and/or coinsurance obligations. A Participating Member will not receive an Explanation of Benefits for these payments.	**HRA Product**

PLAN BOOKLET		
Products excluding Health Savings Account		
	Prepare and make accessible Member benefit booklet drafts to Employer.	**All Products**
UNDERWRITING SERVICES		
1.	5500 Schedule C reporting.	**All Products**
2.	5500 Schedule A or Annual Reconciliation Disclosure reporting (when applicable)	**All Products**
3.	CHLIC's standard Underwriting services: a) benefit design analysis-b) projected cost analysis.	**All Products**

HIPAA INDIVIDUAL RIGHTS		
Products excluding Health Savings Account		
	Handling of requests from Members for access to, amendment and accounting of protected health information, and requests for restrictions and alternative communications as required under federal HIPAA law and regulations, as set out in this Agreement and its Exhibits.	**All Products**
COST CONTAINMENT		
1.	Maximum reimbursable charge determinations of non-Participating Provider charges for covered services.	**All Medical Products (with out-of-network benefits)**
2.	CHLIC's standard cost containment controls: Application of non-duplication and coordination of benefits rules and coordination with Medicare.	**All Medical Products**
3.	Delivery of information, as necessary, regarding standard application of non-duplication or coordination of benefits.	**All Medical and Dental Products**
4.	Review of medical bills in accordance with CHLIC's then current Medical Bill Review program.	**All Medical Products**
5.	Dental Cost Containment, a network of additional participating PPO providers that provide discounts for which CHLIC retains a portion of the savings generated.	**All Dental Products**
6.	Network Savings Program, a national vendor network that provides discounted rates when a Member accesses care through a Network Savings Program contracted provider.	**All Medical Products**
7.	Annual reporting of CHLIC's standard cost containment results upon Employer's request.	**All Medical and Dental Products**
8.	Pharmacy Vendor Recoveries.	**All Pharmacy Products**

	CUSTOMER REPORTING	
1.	Summary reports of medical, dental and pharmacy cost and utilization experience are available through Cigna's web site, CignaAccess.com.	**All Medical, Dental and Pharmacy Products**
2.	CHLIC's standard pharmacy utilization reports.	**Pharmacy Product Only**
3.	Claim Reporting: CHLIC will provide standard banking and financial report information based upon paid claim data. CHLIC will not provide information on incurred-but-not reported claims, projected claims, pre-certifications of coverage, case management information or information on a Member's prognosis or course of treatment. Stop Loss Reporting is an optional service provided at an additional fee to Employers who have stop loss through another entity other than CHLIC. CHLIC will provide its standard reporting only after the stop loss carrier and Employer have executed CHLIC's standard Hold Harmless/Confidentiality Agreement.	**All Medical Products**
4.	CHLIC's standard management and statistical reports for Employer.	**FSA and DFSA Products**
5.	CHLIC's standard Individual Summary Statements for applicable participating Members.	**FSA, DFSA and HRA Products**
6.	CHLIC's standard Health Reimbursement Account, Healthy Awards and/or Healthy Future activity report for Employer.	**HRA Product**
	COMPLIANCE	
	Employer directs CHLIC in administering the Health Care Flexible Spending Account, Healthy Awards, Healthy Futures and/or Health Reimbursement Account benefit to comply with COBRA as follows:	
1.	Each FSA Member who experiences a qualifying event and elects continuation of account coverage in accordance with COBRA will be maintained until the earlier of the end of the Plan Year, the exhaustion of the FSA balance or other termination of the FSA.	**FSA Product**
2.	FSA Members electing continuation of FSA coverage under COBRA will continue contributions at a rate not to exceed 102% of the applicable premium. The Employer may require after-tax contributions, or may allow the continuant to elect a lump-sum salary reduction in the amount required in contributions for the remainder of the coverage period.	**FSA Product**
3.	FSA Members who continue under COBRA and whose contributions have been made as required may submit Reimbursement Requests for themselves and any eligible dependents, for expenses incurred before or after the date of the qualifying event but prior to the end of the coverage period. Requests may be submitted until the earlier of the end of the Plan Year or the termination of the FSA, including any applicable Run-Out Period.	**FSA Product**
4.	The HRA, HA and/or HF of each HRA, HA and/or HF Participating Member who experiences a qualifying event and elects continuation of account coverage in accordance with COBRA will be maintained similar to the maintenance of an active employee. HF Participating Members that have not met their vesting requirements determined by the plan are not required to be offered COBRA for the HF.	**HRA Product**

	MEMBER EXTERNAL REVIEW PROGRAM	
	CHLIC contracts with a minimum of three (3) independent review organizations that meet the Patient Protection and Affordable Care Act (PPACA) external review requirements. Members may appeal eligible claims requiring medical judgment to an external independent review organization which is selected by CHLIC on a random basis. If Employer has chosen not to participate in this program, the Employer may be responsible for making other arrangements to meet the Patient Protection and Affordable Care Act (PPACA) external review requirements.	**All Medical Products**
	MEDICAL MANAGEMENT SERVICES	
	CHLIC provides integrated medical management that includes (depending upon the terms of the Plan) the following core services.	
1.	Pre-Admission Certification and Continued Stay Review (PAC/CSR) services to certify coverage of acute and sub-acute inpatient admissions/stays or provides guidance to appropriate alternative settings. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products**
2.	Case Management and Retrospective Review of Inpatient Care, a service designed to provide assistance to a Member who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support.	**All Medical Products**
3.	Assist providers with resources and tools to enable them to develop long term treatment plans in the management of chronic or catastrophic cases.	**All Medical Products**
4.	The Cigna HealthCare Healthy Babies® Program is a one-time educational mailing which provides Participants with prenatal care education and resources to help them better manage their pregnancy. Other benefits of this program include the 24-Hour Health Information Line℠ and pregnancy information on myCigna.com.	**All Medical Products**
5.	HealthCare Cost and Quality tools on myCigna.com	**All Medical Products**
6.	A panel of physicians and other clinicians to assess the safety and effectiveness of new and emerging medical technologies. The panel meets monthly to review and update coverage policies.	**All Medical Products**
7.	The 24-Hour Health Information Line℠ is a service that provides twenty-four (24) hour toll free access to nurses, who provide answers to healthcare questions, recommend appropriate settings for care and assist Participants in locating physicians. It also includes access to an extensive audio library on a wide range of medical topics.	**All Medical Products**
8.	Cigna LifeSOURCE Transplant Network® contracts with more than one hundred sixty-five (165) independent transplant facilities which includes over seven hundred fifty (750) transplant programs and provides access to solid organ and bone marrow/stem cell transplantation while improving cost containment and reducing financial risk.	**All Medical Products**
9.	A health education program that delivers mailings to Members with certain conditions.	**All Medical Products Except Comprehensive and Indemnity**

10.	If behavioral health services are provided/arranged by Cigna Behavioral Health (CBH), CBH provides utilization review and case management for both inpatient and outpatient, in-network behavioral health services.	**HRA OAP, OAP Products Only**
11.	Implement clinical quality measurements, track and validate performance and initiate continuous quality improvement.	**All Medical Products Except Comprehensive and Indemnity**
12.	Transition of care services to allow Members with defined conditions to continue treatment with non-Participating Providers after enrollment for continued uninterrupted care for a limited time.	**All Medical Products Except Comprehensive and Indemnity**
13.	Focused utilization management of outpatient procedures and identification of appropriate alternatives. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products with Care Management Preferred**
	NETWORK MANAGEMENT SERVICES	
	CHLIC, and/or its affiliates or contracted vendors shall:	
1.	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, fixed per person per period, per diem charges, incentive bonuses, case rates, withholds etc.). The amount and type of negotiated reimbursement may vary depending upon the type of plan. For example, a hospital may accept less for patients enrolled in certain types of plans than others; In addition, CHLIC may contract with Participating Providers and other parties (for example Independent Practice Associations) for performance-based incentive payments to promote quality of care, patient safety and cost efficiency.	**All Medical and Pharmacy Products**
2.	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, fixed per person per period, per diem charges, incentive bonuses, case rates, withholds etc.). In addition, CHLIC may contract with Participating Providers and other parties for performance-based incentive payments to promote quality of care, patient safety and cost efficiency;	**All Dental Products**
3.	Credential and re-credential Participating Providers in accordance with CHLIC's credentialing requirements and ensure that third-party network vendors credential/re-credential Participating Providers in accordance with CHLIC's requirements;	**All Medical, Dental and Pharmacy Products**
4.	Monitor Participating Provider compliance with protocols and procedures for quality, Member satisfaction, and grievance resolution;	**All Medical, Dental and Pharmacy Products**
5.	Facilitate the identification of Participating Providers by Members; and	**All Medical, Dental and Pharmacy Products**
6.	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Medical, Dental and Pharmacy Products**

7.	Access to online and/or on demand medical and health-related consultations via secure telecommunications technologies, telephones and internet where permitted only when delivered by a CHLIC contracted medical Telehealth network of providers (see details on myCigna.com).	**All Medical Products**
	BEHAVIORAL HEALTH	
	CHLIC has contracted with an affiliate, Cigna Behavioral Health ("CBH"), to provide or arrange for the provision of managed in-network behavioral health services, CBH is a Participating Provider, and is reimbursed primarily on a monthly fixed fee basis. This fixed fee for CBH services will be paid as claims and will appear in Employer's monthly reporting and on financial documents. Such payments will be at the relevant monthly rates then in effect. The monthly rates paid to CBH vary depending on geographic location of Members and on benefit design, and may be subject to change. The rates will be made available upon request. The fixed fee also includes lifestyle management programs, a cognitive behavioral modification program, a Complex Psychiatric Case Management program, and a Narcotics Therapy Management program. Behavioral claims from a client specific network are not included in the behavioral monthly fixed fee and will be paid from the Bank Account. In some states, payment for behavioral health services must be paid on a fee-for-service basis. In these states, fee-for-service payments for behavioral health services and the CBH administrative fee (including the lifestyle management programs, a cognitive behavioral modification program a Complex Psychiatric Case Management program and a Narcotics Therapy Management program) will be paid from the Bank Account as claims and will appear in Employer's monthly reporting.	**These services are included in the following products: HRA OAP, OAP**

	CIGNA STAFF MODEL HEALTHPLAN SERVICES	
	The Cigna HealthCare of Arizona, Inc. staff model ("Cigna Medical Group") is a Participating Provider located in metropolitan Phoenix, Arizona. Plan Participants may at some time receive treatment from a Cigna Medical Group ("CMG") facility or provider even if they do not reside in Arizona (as when traveling). Plan Participants utilizing the IPA network will access certain specialty and/or ancillary services (including laboratory and urgent care services) through the CMG system. Lab services are not provided by CMG for Participants in PPO or EPO plans. Except as provided below, for covered services provided to Participants, CMG is paid at the rates in effect at the time of service (as may be revised from time to time). Representative rates for routinely performed services are attached. A complete copy of the rates is available on request under a mutually agreed nondisclosure agreement (NDA). If the Plan requires Participants to select a primary care physician (PCP), Phoenix area Participants who do not select a PCP during open enrollment may be assigned to a CMG PCP. CMG is paid for PCP-required Plans at the rates in effect at the time of service. Primary care services rendered to Participants in Open Access or LocalPlus Plans that do not provide for PCP assignment are paid at the rates then in effect, as described above. CMG may also receive applicable performance-based incentive payments for its participation in programs designed to improve quality, patient safety and affordability.	**All Medical Products**

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

EFFECTIVE JUNE 1, 2016

(Applicable to all Open Access Plus Products)

Department	CPT Code	Description	OAP Rate
All Departments	99213	OFFICE VISIT,EST EXP PROB FOC	$65.80
Adult Medicine	99396	WELL EXAM, EST, 40-64 YEARS	$102.94
Pediatrics	99392	WELL EXAM, EST, 1-4 YEARS	$85.77
Ophthalmology	66984	REMOVE CATARACT, INSERT LEN- Professional Fee only, at a facility	$700.01
Podiatry	11721	DEBRIDEMENT NAIL SIX OR MORE	$39.95
Radiology	71020	CHEST X-RAY, PA & LAT	$30.38
Radiology	G0202 + 77052	SCREENING MAMMOGRAPHY DIGITAL	$141.02
General Surgery	47562	LAPAROSCOPY;CHOLECYSTECTOMY- Professional Fee only, at a facility	$837.79
Optometry	92014	EYE EXAM & TREATMENT	$109.35
Lab	80053	COMPREHENSIVE METABOLIC PANEL	$14.87
Lab	80061	LIPID PANEL	$18.85
ASC (Ambulatory surgical center) / Endoscopy Suite	Grouper 2		$469.00
ASC (Ambulatory surgical center) / Endoscopy Suite	Grouper 8		$1,104.00

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

The Urgent Care case rate excluding radiology and laboratory services is $115.

CMG pharmacy rates (30-day supply):

Brand Name: AWP – 10.56% + $2.75 dispensing fee

Generic: AWP – 35% + $2.75 dispensing fee

Appendix A – Pharmacy Benefit Management Services

PHARMACY BENEFIT MANAGEMENT - DEFINITIONS
Definitions Any capitalized term not defined below shall have the meaning given to such term in the Agreement. Any capitalized term utilized in the Schedule of Financial Charges or Exhibit B shall have the meaning given to such term in the Agreement, including the meanings set forth below. • "Actuarially Estimated" shall mean that the discount(s) listed in the Schedule of Financial Charges are estimated, but not guaranteed, to result in a particular discount for Covered Drugs. Actuarially estimated discounts are calculated based on evaluation of an expected distribution of drug utilization across CHLIC's aggregate self-funded and insured client book of business. As measured in the aggregate for Employer's Pharmacy Benefit, Employer's results may vary based on the Plan-specific factors such as drug mix utilization. • "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"), Covered Drug specific, quantity appropriate actual package size (or the manufacturer-packaged quantity closest to the dispensed size), submitted by a Retail Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy at the time that the Covered Drug is adjudicated. In the event a repackaged or relabeled NDC is dispensed, the lowest cost AWP for the equivalent drug dosage form, strength, Brand Drug / Generic Drug designation, and formulation and package size from a non-repackager or non-relabeler shall be applied. 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, including, for example, any change in the markup, methodologies, processes or algorithms underlying the published AWP(s), CHLIC may adjust any or all of the Rebates, charges, rates, discounts, guarantees and/or fees in connection with CHLIC's administration of the Pharmacy Benefit hereunder, including any that are based on AWP, as it reasonably deems necessary to preserve the economic value or benefit of this Agreement to the Parties as it existed immediately prior to such change. Additionally, and notwithstanding any other provision in this Agreement, CHLIC may replace AWP as its pharmaceutical pricing benchmark with an alternative benchmark and/or may replace Medi-Span, or other such publication, as its source for the AWP or alternative benchmark with a different pricing source, provided that CHLIC adjusts any or all such AWP-based charges or such alternative benchmark-based charges as it reasonably deems necessary to preserve the economic value or benefit of this Agreement to the Parties as it existed immediately prior to such replacement or immediately prior to the event(s) giving rise to such replacement, as the case may be. • "Brand Drug" shall mean a pharmaceutical product, including a Covered Drug that is a prescription drug, including over-the-counter drugs dispensed pursuant to a prescription, medicine, agent, substance, device, supply or other therapeutic product that is not a Generic Drug. • "Business Decision Team" shall mean a committee comprised of voting and non-voting representatives across various Cigna business units such as clinical, medical and business leadership that is duly authorized by Cigna to make decisions regarding coverage treatment of Prescription Drug Products based on clinical findings provided by the P&T Committee, including, but not limited to, decisions regarding tier placement and application of utilization management to Prescription Drug Products • "Cigna Home Delivery Pharmacy" shall mean a duly licensed pharmacy operated by CHLIC or its affiliates, where prescriptions are filled and delivered

via the mail service, which may include Tel-Drug, LLC of Pennsylvania and Tel-Drug, Inc. of South Dakota.

- "Claim", for purposes of this Appendix A, is a claim for coverage under the Pharmacy Benefit.

- "Compound Drug" shall mean a medication that (a) is comprised of two or more gaseous, solid, semi-solid, or liquid ingredients (other than water or flavoring added to any preparation) that are weighed or measured at a pharmacy and then prepared according to the prescriber's order and the pharmacist's art; (b) contains at least one FDA-approved federal legend drug as an active ingredient; (c) is not otherwise generally available in its compound form; and (d) is not a compound preparation administered by infusion or injection.

- "Covered Drugs" shall mean prescription drugs, including over-the-counter drugs dispensed pursuant to a prescription, biologics, medicines, agents, substances, devices, supplies, and other therapeutic products that are prescribed for Members and are covered under the Pharmacy Benefit and shall include all associated standard services usually and customarily rendered by a pharmacy or provider in the normal course of business, including dispensing, administration, counseling and product consultation.

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

- "FDA" shall mean the U.S. Food and Drug Administration.

- "Formulary" shall mean the list of FDA-approved prescription drugs and supplies developed and managed by CHLIC across its self-funded and insured group book of business and that is selected and adopted by Employer. The drugs and supplies included on the Formulary will be modified by CHLIC from time to time as a result of factors including, but not limited to, economic and clinical factors like clinical appropriateness, manufacturer Rebate arrangements and patent expirations. Any changes CHLIC makes to the Formulary are hereby adopted by Employer.

- "Generic Drug" means a pharmaceutical product, including a Covered Drug, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the FDA as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient(s), and which is identified as such in CHLIC's master drug file using indicators from First Databank, Medi-Span, or other nationally recognized source as used by CHLIC across its book of business on the basis of a proprietary algorithm, a summary of which may be made available for review by Employer or, subject to CHLIC's consent, its auditor upon request in accordance with the terms set forth in this Appendix A. Employer and, as applicable, its auditor shall sign a confidentiality agreement acceptable to CHLIC relating specifically to such summary. The reference to a drug by its chemical name does not necessarily mean that the product is recognized as a generic for adjudication, pricing or copay purposes.

  For pricing purposes, a Generic Drug excludes a Covered Drug that is either marketed under three (3) or fewer Abbreviated New Drug Application pursuant to 21 USC §355, and its implementing regulations, or cannot be purchased by the pharmaceutical industry at large from more than one pharmaceutical wholesaler.

- "Maximum Allowable Charge" shall mean the maximum unit price for a Covered Drug included on the applicable MAC List as set forth on such MAC List.

- "MAC List" shall mean a then-current list maintained by CHLIC of prescription drugs, devices, supplies and over-the-counter drugs identified as readily available as a Generic Drug or generally equivalent to a Brand Drug (in which case it may also be on a MAC List) and that, in each case, are deemed to

require or are otherwise capable of pricing management due to the number of manufacturers, utilization and/or pricing volatility.

- "Pharmacy Benefits" shall mean amounts payable for covered pharmacy benefit services and products under the terms of the Plan; Pharmacy Benefits shall be considered Plan Benefits for purposes of this Agreement.

- "P&T Committee" shall mean a committee comprised of both voting and non-voting Cigna-employed clinicians, Medical Directors and Pharmacy Directors and non-employees such as Participating Providers that represent a range of clinical specialties. The committee regularly reviews Prescription Drug Products, including New Prescription Drug Products, for safety and efficacy, the findings of which clinical reviews inform coverage status decisions made by the Business Decision Team. The P&T Committee's review may be based on consideration of, without limitation, FDA-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

- "PBM Proprietary Information" shall mean information relating to CHLIC's pharmacy benefit management products and services, including, without limitation, CHLIC's reporting and web-based applications, eligibility and adjudication systems and coding methodologies, system formats and databanks, clinical or formulary management operations or programs, information and agreements relating to Rebates and other financial information, prescription drug evaluation criteria and coverage policies, drug pricing information, including MAC List and Specialty Drug pricing, paid Claims information integrated into CHLIC's adjudication systems, and pharmaceutical manufacturer, vendor or pharmacy network agreements.

- "Rebate" shall mean the following payments or other consideration paid or payable to CHLIC from manufacturers to the extent arising from or as a result of Covered Drugs dispensed to Members and/or the performance of any pharmacy benefit management services provided under the Agreement.

(a) Payments, rebates and other consideration paid to CHLIC from any manufacturer arising from or as a result of the inclusion or exclusion on any Formulary of Covered Drugs manufactured, sold, marketed, or distributed by any manufacturer;

(b) Rebates, discounts, service fees and other consideration paid to CHLIC from any manufacturer arising from or as a result of any arrangements, commitments, programs or activities involving or relating to utilization (e.g., market share, growth, etc.) of certain prescription drugs within their respective therapeutic categories; and

(c) Rebates, discounts, service fees and other consideration paid to CHLIC from any manufacturer arising from or as a result of any arrangements, commitments, programs or activities involving or relating to services performed by CHLIC where CHLIC is paid or is entitled to fees or other compensation on the basis of the volume or value of prescription drugs or other products that are prescribed or dispensed to CHLIC customers.

However, "Rebates" shall exclude: (i) pricing adjustments, payments and credits made in the ordinary course by any manufacturer on account of product returns, delivery errors or shipping damage or losses arising from drugs and other products purchased from such manufacturer by or on behalf of CHLIC; (ii) pricing discounts paid or credited by a manufacturer to pharmacies affiliated with CHLIC for prescription drugs and other products purchased from such manufacturer; (iii) any fees or other compensation paid by any manufacturer in consideration of any services, products, activities or programs performed, provided or implemented by CHLIC or any of its affiliates for such manufacturer; (iv) payments, rebates or other compensation paid to CHLIC for or by reason of any administrative or other services provided by CHLIC to or for any manufacturer, in connection with administering, computing, invoicing, allocating and/or collecting amounts otherwise constituting Rebates; and (v) rebates or other amounts paid to CHLIC for prescription drugs that are administered or otherwise provided to Members in providers' offices or outpatient clinics.

- "Retail Pharmacy" shall mean any licensed retail pharmacy with which CHLIC has contracted directly or indirectly with a third party, to provide Covered Drugs to Members, and is not a mail order pharmacy. A mail order pharmacy is a pharmacy that primarily fills and delivers pharmaceutical products via the mail service. The term "Retail", when immediately preceding the term "Brand Drug Claim," "Generic Drug Claim," "Specialty Drug Claim," "Specialty Brand Drug Claim, or "Specialty Generic Drug Claim" means that the resulting term (e.g., "Retail Brand Drug Claim") refers to such claim as dispensed by a Retail Pharmacy.

- "Specialty Drug" shall mean a pharmaceutical product, including a Covered Drug, considered by CHLIC to be a Specialty Drug based on consideration of the following factors: (i) whether the pharmaceutical product is prescribed and used for the treatment of a complex, chronic or rare condition; (ii) whether the pharmaceutical product has a high acquisition cost; and, (iii) whether the pharmaceutical product is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Drug may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a pharmaceutical product will be considered a Specialty Drug. The term "Specialty," when immediately preceding the terms "Generic Drug" or "Brand Drug", means that the resulting term (e.g. "Specialty Generic Drug") refers to a Generic Drug or Brand Drug that is considered a Specialty Drug, respectively.

- "Specialty Pharmacy" shall mean a duly licensed pharmacy designated by or operated by CHLIC or its affiliates that primarily dispenses Specialty Drugs or provides services related thereto; provided, however, that when the Cigna Home Delivery Pharmacy dispenses a Specialty Drug, it shall be considered a Specialty Pharmacy hereunder.

- "U&C Charge" shall mean the price the applicable Retail Pharmacy would charge a regular cash-paying customer for a Covered Drug (and any services related to the dispensing thereof) on the day on which the Covered Drug is dispensed, exclusive of applicable taxes.

PHARMACY BENEFIT MANAGEMENT – SERVICES TO BE PROVIDED

1. Retail Pharmacy Network.

(a) General. CHLIC shall maintain a Retail Pharmacy network. Retail Pharmacies included in the network shall provide Covered Drugs to which the Retail Pharmacies have access to Members during their normal business hours in all applicable locations. A list of the Retail Pharmacies included in the network, as updated from time to time, shall be made available to Members online. CHLIC maintains multiple networks and/or sub-networks and may periodically consolidate networks and/or migrate clients, including Employer, between networks and sub-networks. CHLIC shall require each Retail Pharmacy included in the network to meet its requirements for participation in the Retail Pharmacy network, which include, but are not limited to, satisfaction of licensing and insurance requirements.

(b) Retail Pharmacy Audits and Overpayments. CHLIC shall perform desktop and on-site audits of each Retail Pharmacy to ensure that each Retail Pharmacy is complying with the terms of its contract with CHLIC. In the event that CHLIC discovers that an overpayment has been made to a Retail Pharmacy, CHLIC shall take reasonable steps to recover the overpayment pursuant to the terms of this Agreement.

(c) Independent Contractors. The Retail Pharmacies are independent contractors, and CHLIC does not exert direction or control over the pharmacists at Retail Pharmacies in filling prescriptions or performing other pharmaceutical services.

(d) Collection of Cost Sharing. CHLIC shall require Retail Pharmacies to collect all applicable cost-shares from Members.

2. **Cigna Home Delivery Pharmacy.**

(a) General. Members may submit new or refill prescription orders for fulfillment through Cigna Home Delivery Pharmacy or such other mail service pharmacy that CHLIC in its sole discretion may select from time to time. Such orders may be placed via mail, telephone, or electronic means. Subject to Applicable Law, Employer shall permit CHLIC to communicate with Members regarding availability and use of the Cigna Home Delivery Pharmacy and potential cost savings associated therewith. In addition, CHLIC may provide supporting services with respect to the Cigna Home Delivery Pharmacy. Cigna Home Delivery Pharmacy shall deliver all drugs to Members in accordance with its standard procedures, which are available upon reasonable request. For the purposes of clarity, CHLIC does not exert direction or control over the pharmacists at Cigna Home Delivery Pharmacy in filling prescriptions or performing other pharmaceutical services.

(b) Cost Sharing. Members are responsible for payment of the applicable cost sharing to Cigna Home Delivery Pharmacy for each prescription or prescription refill. Employer acknowledges that Cigna Home Delivery Pharmacy may suspend services to a Member who is in default of any cost-sharing obligations, in accordance with Cigna Home Delivery Pharmacy's standard credit policy. If payment of such cost-sharing has not been received from the Member within one hundred twenty (120) days of dispensing of the product, the Plan will be billed for the outstanding amount following the one hundred twenty (120) day collection period.

(c) Affiliation with CHLIC. Tel-Drug of Pennsylvania, LLC and Tel-Drug, Inc. of South Dakota are licensed pharmacy affiliates of CHLIC that fill and deliver Covered Drugs via the mail service.

3. **Claims Processing.**

(a) General. CHLIC shall perform claims processing services for Covered Drugs dispensed by Retail Pharmacies or Cigna Home Delivery Pharmacy. In-network Claims shall be submitted via paper or electronically. Members using out-of-network covered services are required to submit a paper claim form. A separate charge shall apply for submission of any paper claim form, whether in-network or out-of-network. CHLIC does not provide coordination of benefits (COB) services for Claims for drugs dispensed, and electronically processed, at a pharmacy; Claims for Plan Benefits will be processed without consideration of a Member's coverage under another plan.

(b) Drug Utilization Review. CHLIC shall perform a concurrent Drug Utilization Review ("DUR") analysis of each prescription submitted for processing, which may include: (1) prescribed dosage within a safe range; (2) drug-to-drug interaction; (3) drug-to-allergy interaction; (4) age-to-drug interaction; (5) duplicate therapy; (6) quantity limitations; and (7) days' supply. CHLIC's DUR processes shall not override or substitute for the prescriber's, the pharmacist's or other health care provider's professional judgment.

4. **Step Therapy.** CHLIC shall apply a step therapy program that, for some therapeutic classes, requires Members to try, or demonstrate contraindication or intolerance to, more cost-effective, clinically appropriate alternative drugs before CHLIC will approve coverage of non-preferred drugs in the same therapeutic class.

5. **Rebate Management.** CHLIC shall pay Employer amounts equal to the Rebate amounts specified on the Schedule of Financial Charges.

6. **Drug-Related Services.**

(a) Generic Drugs and Brand Drugs. CHLIC shall process Claims regarding Generic Drugs and Brand Drugs.

(b) Specialty Drugs. CHLIC shall process Claims regarding Specialty Drugs subject to the following provisions:

(1) The Specialty Pharmacy shall fill prescriptions for Specialty Drugs based on the professional judgment of the dispensing pharmacist, accepted pharmacy practices and product guidelines.

(2) A list of Specialty Drugs available via the Specialty Pharmacy and pricing with respect thereto shall be made available as in effect on the Effective Date, are set forth in Appendix B. After the Effective Date, Employer may request that CHLIC provide it with an updated list of Specialty Drugs available via the Specialty Pharmacy and pricing with respect thereto.

(3) To the extent acting in the capacity as a mail order pharmacy, the Specialty Pharmacy shall ship Specialty Drugs to Members in accordance with its standard procedures, which are available upon request.

(4) Members are responsible for payment of the applicable cost sharing to the Specialty Pharmacy for each prescription or prescription refill. Employer acknowledges that the Specialty Pharmacy may suspend services to a Member who is in default of any cost-sharing obligations, in accordance with the Specialty Pharmacy's standard credit policy. If payment has not been received from the Member within one hundred twenty (120) days of dispensing, the Plan will be billed following the one hundred twenty (120) day collection period.

(5) For the purposes of clarity, CHLIC does not exert direction or control over the pharmacists at the Specialty Pharmacy in filling prescriptions or performing other pharmaceutical services.

(c) Compound Drugs. CHLIC shall process prescribed Compound Drugs to the extent covered under the Plan. CHLIC shall treat as Covered Drugs only those components of a Compound Drug that would otherwise be treated as Covered Drugs were they not part of a Compound Drug.

7. **Member Communications and Services.**

(a) Member Communication. CHLIC shall provide to Members an ID card and instructions to access Member materials online, including the Formulary, the Retail Pharmacy directory, Cigna Home Delivery Pharmacy information, and an out-of-network Claim reimbursement form.

(b) Rx Savings Messenger. CHLIC may send personalized mailings to Members regarding the Generic Drugs and preferred Brand Drugs and savings available from Cigna Home Delivery Pharmacy.

(c) Call Center. CHLIC shall maintain toll-free customer service lines twenty-four (24) hours per day, seven (7) days per week for the purpose of responding to inquiries from Members regarding Retail Pharmacy, Cigna Home Delivery Pharmacy or Claims issues.

8. **Formulary Management; Clinical Programs; Other Services.**
CHLIC shall provide Formulary management services, which shall include implementing Formulary placement decisions and determinations to apply utilization management requirements made by CHLIC's Business Decision Team. The Business Decision Team makes Formulary determinations based on consideration of clinical and economic factors. Clinical factors may include, but are not limited to, the CHLIC P&T Committee's evaluation

of the place in therapy, relative safety or relative efficacy of the drug, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the drug's acquisition cost including, but not limited to, assessments on the cost effectiveness of the drug and available Rebates. When considering a drug for Formulary placement or other coverage conditions, CHLIC's Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its book-of-business. CHLIC shall also provide the clinical, safety and/or trend programs, or other programs and services selected by Employer as indicated on the Schedule of Financial Charges or otherwise agreed upon by Employer and CHLIC, some of which may require payment of additional fees. If Employer changes its Formulary selection, changes Plan benefit designs, implements over-the-counter plans, implements clinical or trend programs, or otherwise takes an action that has the effect of lowering the amount of Rebates earned hereunder or materially impacting any guarantee, then CHLIC shall have the right, upon notice, to make an equitable adjustment to the rates, fees, and/or Rebates under this Agreement, solely as necessary to return CHLIC to its contracted economic position as of the effective date of such event.

PHARMACY BENEFIT MANAGEMENT – PROGRAM OPERATIONS

1. Implementation of Agreement.

(a) Project Plan. Employer and CHLIC shall develop an agreed upon implementation project plan with respect to the Agreement prior to the Effective Date or prior to the implementation with respect to any new Pharmacy Benefit under this Agreement following the Effective Date.

(b) Initial Data and Commencement of Pharmacy Benefit Management Services. Prior to the Effective Date, Employer shall provide CHLIC with all data and/or documentation necessary for CHLIC to provide the services specified in this Agreement. Such data and/or documentation shall include, but is not necessarily limited to, claims history and Member prior authorization history. Assuming all data specified in the preceding sentence is received sufficiently in advance of the Effective Date, CHLIC shall commence providing services under this Agreement as of the Effective Date.

2. Timely Provision of Data by Employer. Employer acknowledges that CHLIC shall not be held responsible for, and shall be released from, fulfilling any obligation or performing any service under this Agreement if Employer or its designee does not provide accurate information in a timely manner.

3. Reporting. CHLIC shall make available to Employer CHLIC's standard reporting applications, subject to Applicable Law and Exhibit D, including, without limitation, HIPAA and state privacy laws.

4. Claims Data.

(a) Retention. CHLIC shall retain data with respect to Claims for at least seven (7) years from the date the prescription is filled. Following the close of such retention period, CHLIC shall retain and dispose of such Claims data pursuant to its then-current standard policies and procedures, Applicable Law and the business associate agreement described in the Agreement.

(b) Disclosure to Vendor. Upon Employer's written request and subject to execution of a non-disclosure agreement acceptable to CHLIC, CHLIC shall provide prescription Claims data in its standard format to a vendor contracted with Employer's vendor and otherwise acceptable to CHLIC solely for the purposes of such vendor's support of Plan administration functions. Employer agrees that its vendors may not utilize Claims data for any other purpose, including, without limitation, developing products and services, analyzing the Claims data against market benchmarks or CHLIC competitors or adding to a normative database (even if de-identified and/or blinded as to Member and PBM/carrier) for the Employer's or vendor's commercial use. Employer shall be

responsible for any use or disclosure of Claims data, or any services provided, by the vendor. Notwithstanding the foregoing, all audits of any pricing guarantees, Rebate-sharing obligations or Claims processing accuracy shall be conducted in accordance with the terms in this Agreement specifically relating to such audits

(c) De-Identified Data. During and after the term of this Agreement, CHLIC may use Claims, drug, and medical data that has been de-identified in accordance with HIPAA for research, provider evaluation, database maintenance, and other commercial purposes.

This provision shall survive termination or expiration of the Agreement.

5. Claims Processing Audits. Employer may, in accordance with the requirements set forth in Section 6 of the Agreement and at no additional charge while this Agreement is in effect, audit CHLIC's payment of Plan Benefits subject to the conditions set forth in Section 6 of the Agreement.

6. Rebate Audits. Employer may, to the extent specified below, in accordance with the following requirements, and at no additional charge while this Agreement is in effect, audit CHLIC's Rebate payments subject to the following conditions:

(a) Employer shall designate with CHLIC's consent, such consent not to be unreasonably withheld, an independent, third party auditor to conduct the audit (the "Auditor").

(b) The Auditor may audit records directly related to CHLIC's performance of its obligations hereunder regarding Rebates once in each 12-month period upon the following conditions: (1) Employer shall provide at least 45 days written notice to CHLIC; (2) the Auditor (including each auditor conducting the audit) shall be agreeable to Employer and CHLIC; (3) a mutually agreed upon nondisclosure/nonuse contract shall be executed by Employer, the Auditor and CHLIC; (4) the records to be audited shall be no more than two years old as of the date of the audit; (5) the scope of records to be audited shall be as mutually agreed upon by the Auditor and CHLIC as those which are necessary to determine compliance with the Rebate-sharing obligations under this Agreement; (6) the audit shall be conducted at a mutually acceptable time during regular business hours at CHLIC's office where such records are located; (7) records shall not be removed or photocopied without CHLIC's express written consent; (8) the Auditor shall provide its audit report to CHLIC and Employer at the same time; and (9) the Auditor may disclose the aggregate amount of Rebates due Employer but no other details of CHLIC's manufacturer contracts of which the Auditor is apprised, if any.

This provision shall survive termination or expiration of the Agreement.

	PHARMACY BENEFIT MANAGEMENT – FUNDING AND PAYMENT OF CLAIMS; CHARGES	

1. Funding and Payment of Claims. With respect to Pharmacy Benefits, (1) CHLIC may withdraw funds from the Bank Account for the purposes specified in Section 3 of the Agreement five times per month, and (2) any recovered overpayments shall be credited to Employer via a line item on its invoice, less the fee set forth on the Schedule of Financial Charges.

2. Retroactive Member Changes and Terminations. Notwithstanding anything in the Agreement to the contrary, Employer shall remain responsible for all charges and Bank Account Payments incurred or charged through the date CHLIC processed Employer's notice of a retroactive change or termination of a Member's enrollment in the Plan. Notwithstanding anything to the contrary in Section 4.c. of the Agreement, with respect to Pharmacy Benefits, CHLIC generally will implement eligibility updates received from Employer that are compliant with CHLIC's standard electronic format as soon as reasonably

practicable following receipt of such updates.

PHARMACY BENEFIT MANAGEMENT – FIDUCIARY ACKNOWLEDGMENTS

CHLIC offers pharmacy benefit management services for consideration by Employer and other entities. The general parameters of such services and the supporting systems have been developed by CHLIC as part of CHLIC's administration of its general business as a pharmacy benefit manager for entities that sponsor group health plans. The Parties have negotiated the terms of this Agreement in an arm's-length fashion. The Parties assert that neither Party intends that CHLIC shall be a fiduciary with respect to Pharmacy Benefits for either ERISA or state law purposes, and neither Party shall name CHLIC as a "plan fiduciary" with respect to its management of Pharmacy Benefits. Employer acknowledges and agrees that CHLIC (i) does not have discretionary authority or control respecting management of the Pharmacy Benefits, and (ii) does not exercise any authority or control respecting management or disposition of the assets relating to Pharmacy Benefits or of Employer. Rather, Employer retains all such authority and control. The Parties agree that, upon reasonable notice, CHLIC shall have the right to terminate its Pharmacy Benefit services under this Agreement to any Plan and/or Members located in a state that requires a pharmacy benefit manager to be a fiduciary to Employer, the Plan or a Member.

This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT – FINANCIAL ARRANGEMENTS

1. **General.** CHLIC contracts on its own account with Retail Pharmacies to dispense prescription drugs to Employer's Members. Amounts paid to the Retail Pharmacy for Brand Drug, Generic Drug, or Specialty Drug Claims may or may not be equal to the amount charged to Employer and Member, depending on the contract terms between CHLIC and Employer. If the amount paid by Employer and Member does not equal the amount paid by CHLIC to a particular pharmacy, CHLIC will absorb or retain such difference. CHLIC contracts with pharmaceutical manufacturers for Rebates and other remuneration on its own behalf and for its own benefit, and not on behalf of Employer. Accordingly, CHLIC retains all right, title and interest to any and all actual Rebates and other remuneration received from manufacturers. CHLIC will pay Employer amounts equal to all or some portion of the Rebate amounts allocated to Employer, as specified on the Schedule of Financial Charges, from CHLIC's general assets (neither Employer, its Members, nor Employer's Plan retains any beneficial or proprietary interest in CHLIC's general assets). Rebate amounts received vary based on factors including, without limitation, Employer-specific utilization, the volume of utilization as well as Formulary position applicable to the drug or supplies, and adherence to various formulary management controls, benefit design requirements, Claims volume, and in certain instances also may vary based on the product market share. Employer acknowledges and agrees that neither it, its Members nor its Plan will have a right to interest on, or the time value of, any Rebate payments received by CHLIC during the collection period or moneys payable under this section.

2. **Affiliates.** Cigna Home Delivery Pharmacy and any other licensed pharmacy affiliate of CHLIC may maintain product purchase discount arrangements and/or fee-for-service arrangements with pharmaceutical manufacturers and wholesale distributors. Cigna Home Delivery Pharmacy or any other licensed pharmacy affiliate of CHLIC may contract for these arrangements on its own account in support of its pharmacy operations. Many of these arrangements relate to services provided outside of this Agreement and other pharmacy benefit management arrangements and may be entered into without regard to whether a specific drug is on one of the formularies that CHLIC offers to entities that sponsor group health plans. Discounts and fee-for-service payments received by Cigna Home Delivery Pharmacy or any other licensed pharmacy affiliate of CHLIC are not part of the pharmacy benefit management formulary rebates or associated administrative fees or charges paid to CHLIC in connection with CHLIC's pharmacy benefit management formulary rebate programs.

This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT – OBLIGATIONS UPON TERMINATION

Upon notice of termination of this Agreement, the following provisions shall apply with respect to Pharmacy Benefits:

(a) Employer shall notify Members at least thirty (30) days prior to the termination of the Agreement becoming effective of any transition to a successor pharmacy benefit manager.

(b) If mutually agreed upon by CHLIC and Employer, CHLIC shall provide services following termination of the Agreement at CHLIC's then-prevailing rate. Such services, if any, shall be determined by mutual agreement of CHLIC and Employer in advance of the termination of the Agreement becoming effective.

(c) Upon request by Employer and subject to execution of a nondisclosure agreement acceptable to CHLIC, CHLIC shall transition Claims files and/or history to the pharmacy benefit manager or other third party specified by Employer and otherwise acceptable to CHLIC. Any disclosure of Claims files and/or history shall be limited to the information the successor pharmacy benefit manager or other third party needs to implement or administer Employer's pharmacy benefits. CHLIC shall not be required to directly or indirectly release, and Employer shall not release, PBM Proprietary Information to any such third party.

(d) Upon termination of the Agreement for any reason, the Parties shall handle Confidential Information, PBM Proprietary Information and Protected Health Information (as defined in the Business Associate Agreement attached as Exhibit D) pursuant to the terms of the Agreement.

This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT – REMEDIES

(a) **Remedies Not Exclusive.** A Party's right to terminate the Agreement shall not preclude use of any other remedies available to such Party under the Agreement or otherwise, at law, or in equity.

(b) **Suspension of Performance.** In the event (i) Employer makes an assignment for the benefit of creditors; (ii) Employer is the subject of a voluntary or involuntary petition for bankruptcy or is adjudged insolvent or bankrupt; or (iii) a receiver or trustee is appointed for any portion of Employer's rights or property, CHLIC may immediately, and without penalty or any liability for any Employer losses, suspend performance of services hereunder.

(c) **Financial Responsibility.** Without limiting CHLIC's right to terminate this Agreement, CHLIC reserves the right to require Employer to make a deposit as described in this subsection (c). If at any time during the term of this Agreement, Employer fails to comply with the payment terms established hereunder on three (3) or more occasions within a four (4) month period, then CHLIC may request information and/or reasonable assurances and/or a deposit from Employer as to Employer's financial responsibility. Any such deposit shall be in an amount equal to two (2) billing cycles based upon the average of the last three (3) months of billing history. Employer shall provide any such deposit within ten (10) calendar days following the request. CHLIC may apply any such deposit to past due balances and shall return any remaining deposit after the termination of this Agreement and the payment of all amounts payable to CHLIC hereunder. Any deposit provided by Employer shall be paid from the general assets of Employer and not from assets of the Plan and shall not be considered Plan assets for purposes of ERISA.

This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT – CONFIDENTIALITY

1. General. Employer acknowledges and agrees that CHLIC's PBM Proprietary Information constitutes competitively sensitive trade secrets, and that its misuse or mis-disclosure could result in material financial and legal loss or liability to CHLIC, its affiliates and their respective subcontractors. CHLIC shall not be required to disclose PBM Proprietary Information to Employer, or its vendor or designee, except to the extent necessary for Employer to exercise any audit rights expressly provided hereunder or perform other Plan administration functions. If CHLIC discloses PBM Proprietary Information to Employer, or, if CHLIC consents, to the Employer's vendor or designee, CHLIC may require Employer, or its vendor or designee, to execute a non-disclosure agreement specifically relating to the requested PBM Proprietary Information. Notwithstanding the foregoing, in no event will CHLIC be required to disclose information related to, or including, its pharmacy network agreements, vendor agreements or pharmaceutical manufacturer agreements. Employer agrees that it and its vendors may not utilize PBM Proprietary Information for any purpose other than performing Plan administration functions, including, without limitation, developing products and services, de-identifying, blinding or analyzing the PBM Proprietary Information against market benchmarks or CHLIC competitors or adding to a normative database for the Employer's, or vendor's or designee's, commercial use. For the purposes of clarity, information shall not cease to qualify as PBM Proprietary Information if Employer or its vendor or designee de-identifies and/or blinds the PBM Proprietary Information such that the information cannot be traced or identified to a Member or CHLIC, its affiliates or their respective subcontractors. Employer shall be solely responsible for any disclosure of PBM Proprietary Information by CHLIC to Employer or its vendor or designee, or any subsequent use or disclosure by Employer or its vendor or designee, or services provided by the same. Notwithstanding the foregoing, in no event will CHLIC be required to disclose to Employer, or its vendor or designee, information related to, or including, its pharmacy network agreements, vendor agreements or pharmaceutical manufacturer agreements.

2. Compelled Disclosures. If at any time Employer, or its vendor or designee, is required by law, court order or other valid legal process to disclose any Confidential Information, it will promptly notify CHLIC prior to any such compelled disclosure and, upon request, cooperate with CHLIC in seeking a protective order or other available relief to contest or limit the scope of such compelled disclosure.

3. Return or Destruction of Information. At any time upon CHLIC's request or upon expiration or termination of this Appendix A or the Agreement, whichever occurs first, Employer will, at CHLIC's option, promptly deliver, or, as the case may be, compel its vendor or designee to deliver, to CHLIC all PBM Proprietary Information or other Confidential Information (or such portion thereof as requested) and not retain any copies in whole or in part of such PBM Proprietary Information or other Confidential Information, or securely destroy or dispose, or, as the case may be, compel its vendor or designee to destroy or dispose, of those portions of documents and other materials in any form, including electronic form, prepared by or received by the Employer or its vendor or designee, that contain or reflect such PBM Proprietary Information or other Confidential Information. Employer, or its vendor or designee, shall certify such return and destruction, as the case may be, to CHLIC.

Appendix B - Cigna Home Delivery Pharmacy Specialty Drug List

THIS SPECIALTY DRUG LIST IS CONFIDENTIAL, PROPRIETARY INFORMATION OF CHLIC. IT IS PROVIDED SOLELY FOR EMPLOYER'S PLAN ADMINISTRATION PURPOSES. RE-DISCLOSURE IS STRICTLY PROHIBITED EXCEPT AS OTHERWISE PROVIDED BY APPLICABLE LAW. CHLIC RESERVES ALL LEGAL RIGHTS AND REMEDIES TO ENFORCE THESE PROHIBITIONS ON USE AND DISCLOSURE.

Currently Marketed Specialty Drugs on this Specialty Drug List. The discounts in this Specialty Drug List are the discounts that will be adjudicated in CHLIC's claim processing system for the drug indicated when dispensed by Cigna Home Delivery Pharmacy, subject to all of the following.

- Any or all of the discounts in this Specialty Drug List may be adjusted by CHLIC to the extent reasonably necessary to preserve the economic value of this Agreement as it existed immediately prior to the occurrence of any of the following events: a major change in market conditions affecting the pharmaceutical or pharmacy benefit management market, a drug shortage in the market, an issue involving the safety of the drug supply, or similar market situation.
- The discounts in this Specialty Drug List are based on the terms and design of the Pharmacy Benefit that Employer has adopted and disclosed to CHLIC. Accordingly, if Employer fails to disclose to CHLIC, for example, that it uses or intends to use a consumer-driven health plan, a major cost-sharing program, or a utilization management program promoting generic or OTC drugs over brand drugs, CHLIC may adjust the discounts as it reasonably deems necessary to preserve the economic value or benefit of this Agreement as CHLIC anticipated based on the terms and design of the Pharmacy Benefit previously disclosed to CHLIC and prior to CHLIC's discovery of the Pharmacy Benefit design feature that materially impacts CHLIC's discounts in this Specialty Drug List.
- The discounts in this Specialty Drug List shall not apply to Compound Drug claims, Claims that process at U&C, and direct member reimbursement (DMR) Claims.
- Any or all of the discounts in this Specialty Drug List may be adjusted by CHLIC to the extent reasonably necessary to preserve the economic value of this Agreement as it existed immediately prior to the occurrence of any of the following events: (a) there are any significant changes in the composition of CHLIC's pharmacy network or in CHLIC's pharmacy network contract compensation rates, or the structure of the pharmacy stores/chains/vendors that are contracted with CHLIC, including but not limited to disruption in the retail pharmacy delivery model, or bankruptcy of a chain pharmacy; or (b) there is a change in government laws or regulations which has a significant impact on pharmacy claim costs; or (c) any material manufacturer-rebate contracts with or for the benefit of CHLIC are terminated or modified in whole or in part; or (d) there is any legal action or Law that materially affects or could materially affect the manner in which CHLIC's rebate program is administered or an existing Law is interpreted so as to materially affect or potentially have a material effect on CHLIC's administration of the Pharmacy Benefit; or (e) there is a material change in the Plan or the Plan's Pharmacy Benefit that is initiated by Employer which impacts CHLIC's costs.

New-to-Market Specialty Products. Specialty Drug Claims that are for new-to-market drugs will have a minimum market-introduction guaranteed discount of 11.45% off the drug's AWP.

STANDARD Level Specialty Drug List Cigna HOME DELIVERY SPECIALTY DRUG DISCOUNTS For Brand drugs as of 4/1/2017		
CONDITION	**BRAND NAME**	**AWP DISCOUNT**
ALS	RILUTEK	13.54%
AMD	EYLEA	11.45%
ANEMIA	MIRCERA	11.45%
ANGIOEDEMA	FIRAZYR	11.45%
ANTI-COAGULANT	ARGATROBAN	11.45%
ANTI-INFECTIVE	BETHKIS	11.45%
ANTI-INFECTIVE	CYTOGAM	11.45%
ANTI-INFECTIVE	CYTOVENE	11.45%
ANTI-INFECTIVE	FUZEON	11.45%
ANTI-INFECTIVE	KITABIS PAK	11.45%
ANTI-INFECTIVE	TOBI	11.45%
ANTI-PSYCHOTIC	NUPLAZID	13.54%
APLASTIC ANEMIA	PROMACTA	13.54%
ASTHMA	CINQAIR	11.45%
ASTHMA	NUCALA	11.45%
ASTHMA	XOLAIR	11.45%
BILIARY CIRRHOSIS	OCALIVA	13.54%
CANCER	KISQALI	13.54%
CANCER	LARTRUVO	11.46%
CANCER	RUBRACA	11.45%
CANCER - ANCILLARY/ADJUVANT	AKYNZEO	13.54%
CANCER - ANCILLARY/ADJUVANT	ALOXI	11.45%
CANCER - ANCILLARY/ADJUVANT	ANZEMET	13.54%
CANCER - ANCILLARY/ADJUVANT	ARANESP	11.45%
CANCER - ANCILLARY/ADJUVANT	COMETRIQ	13.54%
CANCER - ANCILLARY/ADJUVANT	ELIGARD	11.45%
CANCER - ANCILLARY/ADJUVANT	ELITEK	11.45%
CANCER - ANCILLARY/ADJUVANT	EMEND	13.54%
CANCER - ANCILLARY/ADJUVANT	EPOGEN	11.45%
CANCER - ANCILLARY/ADJUVANT	ETHYOL	11.45%
CANCER - ANCILLARY/ADJUVANT	FIRMAGON	11.45%
CANCER - ANCILLARY/ADJUVANT	FUSILEV	11.45%

CANCER - ANCILLARY/ADJUVANT	GRANIX	11.45%
CANCER - ANCILLARY/ADJUVANT	LEUKINE	11.45%
CANCER - ANCILLARY/ADJUVANT	LUPANETA	11.45%
CANCER - ANCILLARY/ADJUVANT	LUPRON DEPOT	11.45%
CANCER - ANCILLARY/ADJUVANT	MESNEX	11.45%
CANCER - ANCILLARY/ADJUVANT	NEULASTA	13.00%
CANCER - ANCILLARY/ADJUVANT	NEUPOGEN	11.45%
CANCER - ANCILLARY/ADJUVANT	PROCRIT	11.45%
CANCER - ANCILLARY/ADJUVANT	VARUBI	13.54%
CANCER - ANCILLARY/ADJUVANT	VISTOGARD	13.54%
CANCER - ANCILLARY/ADJUVANT	VORAXAZE	11.45%
CANCER - ANCILLARY/ADJUVANT	ZARXIO	13.00%
CANCER - ANCILLARY/ADJUVANT	ZOLADEX	11.45%
CANCER - CHEMOTHERAPY	ABRAXANE	11.45%
CANCER - CHEMOTHERAPY	ADCETRIS	15.00%
CANCER - CHEMOTHERAPY	AFINITOR	13.54%
CANCER - CHEMOTHERAPY	AFINITOR DISPERZ	13.54%
CANCER - CHEMOTHERAPY	AGRYLIN	13.54%
CANCER - CHEMOTHERAPY	ALECENSA	13.54%
CANCER - CHEMOTHERAPY	ALIMTA	11.45%
CANCER - CHEMOTHERAPY	ALKERAN	11.45%
CANCER - CHEMOTHERAPY	ARRANON	11.45%
CANCER - CHEMOTHERAPY	ARZERRA	11.45%
CANCER - CHEMOTHERAPY	AVASTIN	11.45%
CANCER - CHEMOTHERAPY	BELEODAQ	11.45%
CANCER - CHEMOTHERAPY	BENDEKA	11.45%
CANCER - CHEMOTHERAPY	BICNU	11.45%
CANCER - CHEMOTHERAPY	BLINCYTO	11.45%
CANCER - CHEMOTHERAPY	BOSULIF	13.54%
CANCER - CHEMOTHERAPY	BUSULFEX	11.45%
CANCER - CHEMOTHERAPY	CABOMETYX	13.54%
CANCER - CHEMOTHERAPY	CAMPATH	11.45%
CANCER - CHEMOTHERAPY	CAMPTOSAR	11.45%
CANCER - CHEMOTHERAPY	CAPRELSA	11.45%
CANCER - CHEMOTHERAPY	CASODEX	13.54%
CANCER - CHEMOTHERAPY	CERUBIDINE	11.45%
CANCER - CHEMOTHERAPY	CLOLAR	11.45%

CANCER - CHEMOTHERAPY	COSMEGEN	11.45%
CANCER - CHEMOTHERAPY	COTELLIC	13.54%
CANCER - CHEMOTHERAPY	CYRAMZA	11.45%
CANCER - CHEMOTHERAPY	DACOGEN	11.45%
CANCER - CHEMOTHERAPY	DARZALEX	11.45%
CANCER - CHEMOTHERAPY	DEPOCYT	11.45%
CANCER - CHEMOTHERAPY	DOCEFREZ	11.45%
CANCER - CHEMOTHERAPY	DOXIL	11.45%
CANCER - CHEMOTHERAPY	ELLENCE	11.45%
CANCER - CHEMOTHERAPY	EMCYT	13.54%
CANCER - CHEMOTHERAPY	EMPLICITI	11.45%
CANCER - CHEMOTHERAPY	ERBITUX	11.45%
CANCER - CHEMOTHERAPY	ERIVEDGE	13.54%
CANCER - CHEMOTHERAPY	ERWINAZE	11.45%
CANCER - CHEMOTHERAPY	ETOPOPHOS	11.45%
CANCER - CHEMOTHERAPY	EVOMELA	11.45%
CANCER - CHEMOTHERAPY	FARYDAK	13.54%
CANCER - CHEMOTHERAPY	FASLODEX	11.45%
CANCER - CHEMOTHERAPY	FLUDARA	11.45%
CANCER - CHEMOTHERAPY	FOLOTYN	11.45%
CANCER - CHEMOTHERAPY	FUDR	11.45%
CANCER - CHEMOTHERAPY	GAZYVA	11.45%
CANCER - CHEMOTHERAPY	GEMZAR	11.45%
CANCER - CHEMOTHERAPY	GILOTRIF	13.54%
CANCER - CHEMOTHERAPY	GLEEVEC	13.54%
CANCER - CHEMOTHERAPY	GLIADEL WAFER	12.91%
CANCER - CHEMOTHERAPY	HALAVEN	11.45%
CANCER - CHEMOTHERAPY	HERCEPTIN	11.45%
CANCER - CHEMOTHERAPY	HEXALEN	13.54%
CANCER - CHEMOTHERAPY	HYCAMTIN	13.54%
CANCER - CHEMOTHERAPY	IBRANCE	13.54%
CANCER - CHEMOTHERAPY	ICLUSIG	13.54%
CANCER - CHEMOTHERAPY	IDAMYCIN PFS	11.45%
CANCER - CHEMOTHERAPY	IFEX	11.45%
CANCER - CHEMOTHERAPY	IMBRUVICA	13.54%
CANCER - CHEMOTHERAPY	IMLYGIC	11.45%
CANCER - CHEMOTHERAPY	INLYTA	9.00%

CANCER - CHEMOTHERAPY	IRESSA	13.54%
CANCER - CHEMOTHERAPY	ISTODAX	11.45%
CANCER - CHEMOTHERAPY	IXEMPRA	11.45%
CANCER - CHEMOTHERAPY	JEVTANA	11.45%
CANCER - CHEMOTHERAPY	KADCYLA	11.45%
CANCER - CHEMOTHERAPY	KEYTRUDA	11.45%
CANCER - CHEMOTHERAPY	KYPROLIS	11.45%
CANCER - CHEMOTHERAPY	LENVIMA	13.54%
CANCER - CHEMOTHERAPY	LONSURF	13.54%
CANCER - CHEMOTHERAPY	LYNPARZA	13.54%
CANCER - CHEMOTHERAPY	MARQIBO	11.45%
CANCER - CHEMOTHERAPY	MATULANE	13.54%
CANCER - CHEMOTHERAPY	MEKINIST	13.54%
CANCER - CHEMOTHERAPY	MUSTARGEN	11.45%
CANCER - CHEMOTHERAPY	NAVELBINE	11.45%
CANCER - CHEMOTHERAPY	NEXAVAR	11.45%
CANCER - CHEMOTHERAPY	NEXAVIR	11.45%
CANCER - CHEMOTHERAPY	NINLARO	13.54%
CANCER - CHEMOTHERAPY	NIPENT	11.45%
CANCER - CHEMOTHERAPY	ODOMZO	13.54%
CANCER - CHEMOTHERAPY	ONCASPAR	11.45%
CANCER - CHEMOTHERAPY	ONIVYDE	11.45%
CANCER - CHEMOTHERAPY	OPDIVO	11.45%
CANCER - CHEMOTHERAPY	PANRETIN	11.45%
CANCER - CHEMOTHERAPY	PERJETA	11.45%
CANCER - CHEMOTHERAPY	POMALYST	13.54%
CANCER - CHEMOTHERAPY	PORTRAZZA	11.45%
CANCER - CHEMOTHERAPY	PROLEUKIN	11.45%
CANCER - CHEMOTHERAPY	PROVENGE	11.45%
CANCER - CHEMOTHERAPY	REVLIMID	5.00%
CANCER - CHEMOTHERAPY	RITUXAN	11.45%
CANCER - CHEMOTHERAPY	SPRYCEL	13.54%
CANCER - CHEMOTHERAPY	STIVARGA	13.54%
CANCER - CHEMOTHERAPY	SUPPRELIN	11.45%
CANCER - CHEMOTHERAPY	SUTENT	13.54%
CANCER - CHEMOTHERAPY	SYLATRON	11.45%
CANCER - CHEMOTHERAPY	SYLVANT	11.45%

CANCER - CHEMOTHERAPY	SYNRIBO	11.45%
CANCER - CHEMOTHERAPY	TAFINLAR	13.54%
CANCER - CHEMOTHERAPY	TAGRISSO	13.54%
CANCER - CHEMOTHERAPY	TARCEVA	13.54%
CANCER - CHEMOTHERAPY	TARGRETIN	13.54%
CANCER - CHEMOTHERAPY	TASIGNA	13.54%
CANCER - CHEMOTHERAPY	TAXOTERE	11.45%
CANCER - CHEMOTHERAPY	TECENTRIQ	11.45%
CANCER - CHEMOTHERAPY	TEMODAR	13.54%
CANCER - CHEMOTHERAPY	THALOMID	13.54%
CANCER - CHEMOTHERAPY	TORISEL	11.45%
CANCER - CHEMOTHERAPY	TREANDA	11.45%
CANCER - CHEMOTHERAPY	TRELSTAR	11.45%
CANCER - CHEMOTHERAPY	TRISENOX	11.45%
CANCER - CHEMOTHERAPY	TYKERB	13.54%
CANCER - CHEMOTHERAPY	UNITUXIN	11.45%
CANCER - CHEMOTHERAPY	VALCHLOR	11.45%
CANCER - CHEMOTHERAPY	VALSTAR	11.45%
CANCER - CHEMOTHERAPY	VANTAS	11.45%
CANCER - CHEMOTHERAPY	VECTIBIX	11.45%
CANCER - CHEMOTHERAPY	VELCADE	11.45%
CANCER - CHEMOTHERAPY	VENCLEXTA	13.54%
CANCER - CHEMOTHERAPY	VIDAZA	11.45%
CANCER - CHEMOTHERAPY	VOTRIENT	13.54%
CANCER - CHEMOTHERAPY	XALKORI	11.45%
CANCER - CHEMOTHERAPY	XELODA	13.54%
CANCER - CHEMOTHERAPY	XTANDI	13.54%
CANCER - CHEMOTHERAPY	YERVOY	11.45%
CANCER - CHEMOTHERAPY	YONDELIS	11.45%
CANCER - CHEMOTHERAPY	ZALTRAP	11.45%
CANCER - CHEMOTHERAPY	ZANOSAR	11.45%
CANCER - CHEMOTHERAPY	ZELBORAF	13.54%
CANCER - CHEMOTHERAPY	ZEVALIN	11.45%
CANCER - CHEMOTHERAPY	ZOLINZA	13.54%
CANCER - CHEMOTHERAPY	ZYDELIG	13.54%
CANCER - CHEMOTHERAPY	ZYKADIA	11.45%
CANCER - CHEMOTHERAPY	ZYTIGA	11.45%

CERVICAL DYSTONIA	XEOMIN	11.45%
CROHN'S DISEASE	STELARA	9.00%
CYSTIC FIBROSIS	CAYSTON	11.45%
CYSTIC FIBROSIS	KALYDECO	13.54%
CYSTIC FIBROSIS	ORKAMBI	13.54%
CYSTINOSIS	CYSTAGON	13.54%
ENZYME DISORDER	ADAGEN	11.45%
ENZYME DISORDER	ALDURAZYME	12.00%
ENZYME DISORDER	ARALAST	11.45%
ENZYME DISORDER	ARALAST NP	13.54%
ENZYME DISORDER	CERDELGA	13.00%
ENZYME DISORDER	CEREZYME	12.00%
ENZYME DISORDER	ELAPRASE	11.45%
ENZYME DISORDER	ELELYSO	11.45%
ENZYME DISORDER	FABRAZYME	12.00%
ENZYME DISORDER	GLASSIA	11.45%
ENZYME DISORDER	LUMIZYME	12.00%
ENZYME DISORDER	NAGLAZYME	12.00%
ENZYME DISORDER	ORFADIN	13.54%
ENZYME DISORDER	PROCYSBI	13.54%
ENZYME DISORDER	PROLASTIN	11.45%
ENZYME DISORDER	STRENSIQ	11.45%
ENZYME DISORDER	SUCRAID	15.00%
ENZYME DISORDER	VIMIZIM	15.00%
ENZYME DISORDER	VPRIV	12.00%
ENZYME DISORDER	ZAVESCA	13.54%
ENZYME DISORDER	ZEMAIRA	11.45%
FACTOR X DEFICIENCY	COAGADEX	26.50%
GROWTH HORMONE DEFICIENCY	EGRIFTA	11.45%
GROWTH HORMONE DEFICIENCY	GATTEX	11.45%
GROWTH HORMONE DEFICIENCY	GENOTROPIN	11.45%
GROWTH HORMONE DEFICIENCY	HUMATROPE	11.45%
GROWTH HORMONE DEFICIENCY	INCRELEX	0.00%
GROWTH HORMONE DEFICIENCY	NORDITROPIN	11.45%
GROWTH HORMONE DEFICIENCY	NUTROPIN	11.45%
GROWTH HORMONE DEFICIENCY	OMNITROPE	11.45%
GROWTH HORMONE DEFICIENCY	SAIZEN	11.45%

GROWTH HORMONE DEFICIENCY	SEROSTIM	11.45%
GROWTH HORMONE DEFICIENCY	ZORBTIVE	11.45%
HAE	BERINERT	11.45%
HAE	CINRYZE	11.45%
HEMOPHILIA	ADVATE	34.00%
HEMOPHILIA	ADYNOVATE	26.50%
HEMOPHILIA	AFSTYLA	26.50%
HEMOPHILIA	ALPHANATE	32.00%
HEMOPHILIA	ALPHANINE SD	36.00%
HEMOPHILIA	ALPROLIX	11.00%
HEMOPHILIA	AMICAR	13.54%
HEMOPHILIA	BEBULIN	11.45%
HEMOPHILIA	BENEFIX	13.50%
HEMOPHILIA	CORIFACT	11.45%
HEMOPHILIA	CYKLOKAPRON	11.45%
HEMOPHILIA	ELOCTATE	25.00%
HEMOPHILIA	FEIBA	28.00%
HEMOPHILIA	FEIBA VH IMMUNO	28.00%
HEMOPHILIA	HELIXATE	31.25%
HEMOPHILIA	HEMOFIL M	40.00%
HEMOPHILIA	HUMATE-P	30.00%
HEMOPHILIA	IDELVION	15.00%
HEMOPHILIA	IXINITY	24.00%
HEMOPHILIA	KOATE	30.20%
HEMOPHILIA	KOATE-DVI	30.20%
HEMOPHILIA	KOGENATE	36.45%
HEMOPHILIA	KOVALTRY	34.00%
HEMOPHILIA	LYSTEDA	11.45%
HEMOPHILIA	MONOCLATE	30.00%
HEMOPHILIA	MONOCLATE-P	30.00%
HEMOPHILIA	MONONINE	24.00%
HEMOPHILIA	NOVOEIGHT	26.50%
HEMOPHILIA	NOVOSEVEN	26.50%
HEMOPHILIA	NUWIQ	26.50%
HEMOPHILIA	OBIZUR	31.25%
HEMOPHILIA	PROFILNINE	22.50%
HEMOPHILIA	RECOMBINATE	37.50%

HEMOPHILIA	RIXUBIS	30.00%
HEMOPHILIA	STIMATE	11.45%
HEMOPHILIA	THROMBATE	11.45%
HEMOPHILIA	TRETTEN	11.45%
HEMOPHILIA	VONVENDI	26.50%
HEMOPHILIA	WILATE	25.00%
HEMOPHILIA	XYNTHA	30.00%
HEPATITIS B	BARACLUDE	13.54%
HEPATITIS B	HEPAGAM	11.45%
HEPATITIS B	HEPAGAM B	11.45%
HEPATITIS B	HEPSERA	13.54%
HEPATITIS B	HYPERHEP B S-D	11.45%
HEPATITIS B	NABI-HB	11.45%
HEPATITIS B	TALTZ	11.45%
HEPATITIS B	TYZEKA	13.54%
HEPATITIS B	VEMLIDY	13.54%
HEPATITIS C	ALFERON N	11.45%
HEPATITIS C	COPEGUS	13.54%
HEPATITIS C	DAKLINZA	13.54%
HEPATITIS C	EPCLUSA	13.54%
HEPATITIS C	HARVONI	46.87%
HEPATITIS C	INTRON	11.45%
HEPATITIS C	OLYSIO	13.54%
HEPATITIS C	PEGASYS	11.45%
HEPATITIS C	PEGINTRON	11.45%
HEPATITIS C	REBETOL	13.54%
HEPATITIS C	RIBAPAK	13.54%
HEPATITIS C	RIBASPHERE	75.00%
HEPATITIS C	SOVALDI	30.21%
HEPATITIS C	TECHNIVIE	13.54%
HEPATITIS C	VIEKIRA	13.54%
HEPATITIS C	ZEPATIER	13.45%
HEREDITARY OROTIC ACIDURIA	XURIDEN	13.45%
HIV	APTIVUS	13.54%
HIV	ATRIPLA	13.54%
HIV	COMBIVIR	13.54%
HIV	COMPLERA	13.54%

HIV	CRIXIVAN	13.54%
HIV	DESCOVY	13.54%
HIV	EDURANT	13.54%
HIV	EMTRIVA	13.54%
HIV	EPIVIR	13.54%
HIV	EPIVIR HBV	13.54%
HIV	EPZICOM	13.54%
HIV	EVOTAZ	13.54%
HIV	GENVOYA	13.54%
HIV	INTELENCE	11.45%
HIV	INVIRASE	13.54%
HIV	ISENTRESS	13.54%
HIV	KALETRA	13.54%
HIV	LEXIVA	13.54%
HIV	NORVIR	13.54%
HIV	ODEFSEY	13.54%
HIV	PREZCOBIX	13.54%
HIV	PREZISTA	13.54%
HIV	RESCRIPTOR	13.54%
HIV	RETROVIR	13.54%
HIV	REYATAZ	13.54%
HIV	SELZENTRY	13.54%
HIV	STRIBILD	13.54%
HIV	SUSTIVA	13.54%
HIV	TIVICAY	13.54%
HIV	TRIUMEQ	13.54%
HIV	TRIZIVIR	13.54%
HIV	TRUVADA	13.54%
HIV	TYBOST	13.54%
HIV	VIDEX	13.54%
HIV	VIRACEPT	13.54%
HIV	VIRAMUNE	13.54%
HIV	VIREAD	13.54%
HIV	VITEKTA	13.54%
HIV	ZERIT	13.54%
HIV	ZIAGEN	13.54%
HOMOCYSTINURIA	CYSTADANE	13.54%

HYPERCALCEMIA	ZOMETA	11.45%
HYPERLIPIDEMIA	PRALUENT	11.45%
HYPERLIPIDEMIA	REPATHA	11.45%
HYPERPARATHYROIDISM	ZEMPLAR	11.45%
HYPONATREMIA	SAMSCA	13.54%
INFERTILITY	BRAVELLE	11.45%
INFERTILITY	CETROTIDE	13.00%
INFERTILITY	FOLLISTIM AQ	13.00%
INFERTILITY	GONAL-F	13.00%
INFERTILITY	GONAL-F RFF	13.00%
INFERTILITY	LUVERIS	11.45%
INFERTILITY	MENOPUR	13.00%
INFERTILITY	NOVAREL	13.00%
INFERTILITY	OVIDREL	13.00%
INFERTILITY	PREGNYL	13.00%
IUD	KYLEENA	11.00%
IUD	LILETTA	11.00%
IUD	MIRENA	11.00%
IUD	SKYLA	7.00%
IVIG	BIVIGAM	27.08%
IVIG	CARIMUNE NF NANOFILTERED	30.00%
IVIG	CUVITRU	28.00%
IVIG	FLEBOGAMMA DIF	20.00%
IVIG	GAMASTAN S-D	18.00%
IVIG	GAMMAGARD	33.00%
IVIG	GAMMAGARD S-D	37.00%
IVIG	GAMMAKED	32.50%
IVIG	GAMMAPLEX	27.08%
IVIG	GAMUNEX	27.08%
IVIG	GAMUNEX-C	28.00%
IVIG	HIZENTRA	28.00%
IVIG	HYQVIA	27.00%
IVIG	OCTAGAM	40.00%
IVIG	PRIVIGEN	35.00%
JOINT/BONE NOC	MACI	11.45%
LIPID LOWERING	KYNAMRO	11.45%
LYSOSOMAL ACID LIPASE DEFICIENCY	KANUMA	11.45%

MACULAR DEGENERATION	LUCENTIS	11.45%
MULTIPLE SCLEROSIS	AMPYRA	12.00%
MULTIPLE SCLEROSIS	AUBAGIO	12.00%
MULTIPLE SCLEROSIS	AVONEX	11.45%
MULTIPLE SCLEROSIS	BETASERON	11.45%
MULTIPLE SCLEROSIS	COPAXONE	11.45%
MULTIPLE SCLEROSIS	EXTAVIA	11.45%
MULTIPLE SCLEROSIS	GILENYA	11.89%
MULTIPLE SCLEROSIS	LEMTRADA	11.45%
MULTIPLE SCLEROSIS	PLEGRIDY	11.45%
MULTIPLE SCLEROSIS	REBIF	11.45%
MULTIPLE SCLEROSIS	TECFIDERA	12.00%
MULTIPLE SCLEROSIS	TYSABRI	15.00%
MULTIPLE SCLEROSIS	ZINBRYTA	11.45%
MUSCULAR DYSTROPHY	EXONDYS	11.45%
MUSCULAR/MOVEMENT	EMFLAZA	13.54%
MUSCULAR/MOVEMENT	XENAZINE	13.54%
MYELOFIBROSIS	JAKAFI	13.54%
OSTEOARTHRITIS	GELSYN-3	11.45%
OSTEOARTHRITIS	HYMOVIS	11.45%
OTHER	ACTHAR	8.55%
OTHER	ACTHREL	11.45%
OTHER	ACTIMMUNE	11.45%
OTHER	AMVISC	11.45%
OTHER	AMVISC PLUS	11.45%
OTHER	ARCALYST	11.45%
OTHER	ARIXTRA	11.45%
OTHER	BONIVA	11.45%
OTHER	BOTOX	11.45%
OTHER	BOTOX COSMETIC	11.45%
OTHER	CHOLBAM	13.54%
OTHER	DYSPORT	11.45%
OTHER	ESBRIET	13.54%
OTHER	EXJADE	13.54%
OTHER	FORTEO	11.45%
OTHER	FRAGMIN	11.45%
OTHER	HYALGAN	11.45%

OTHER	HYLENEX	11.45%
OTHER	HYPERRAB S-D	11.45%
OTHER	ILARIS	11.45%
OTHER	ILUVIEN	11.45%
OTHER	IMOGAM RABIES-HT	11.45%
OTHER	IPRIVASK	11.45%
OTHER	JADENU	13.54%
OTHER	JETREA	11.45%
OTHER	JUXTAPID	13.54%
OTHER	KALBITOR	11.45%
OTHER	KCENTRA	11.45%
OTHER	KRYSTEXXA	11.45%
OTHER	KUVAN	11.45%
OTHER	LOVENOX	11.45%
OTHER	MACUGEN	11.45%
OTHER	MONOVISC	11.45%
OTHER	MYALEPT	11.45%
OTHER	MYOBLOC	11.45%
OTHER	NATPARA	11.45%
OTHER	NATRECOR	11.45%
OTHER	NORTHERA	13.54%
OTHER	NPLATE	11.45%
OTHER	OFEV	13.54%
OTHER	ORTHOVISC	11.45%
OTHER	PANHEMATIN	11.45%
OTHER	PHOTOFRIN	11.45%
OTHER	PRAXBIND	11.45%
OTHER	PRIALT	11.45%
OTHER	PROLIA	11.45%
OTHER	PULMOZYME	11.45%
OTHER	RAPLIXA	11.45%
OTHER	RECLAST	11.45%
OTHER	REFLUDAN	11.45%
OTHER	RIASTAP	23.00%
OTHER	RUCONEST	11.45%
OTHER	SABRIL	13.54%
OTHER	SANDOSTATIN	11.45%

OTHER	SENSIPAR	13.54%
OTHER	SIGNIFOR	11.45%
OTHER	SOLIRIS	12.83%
OTHER	SOMATULINE	11.45%
OTHER	SOMAVERT	11.45%
OTHER	SYNAREL	11.45%
OTHER	SYNVISC	14.80%
OTHER	SYNVISC-ONE	14.80%
OTHER	VIRAZOLE	11.45%
OTHER	VISUDYNE	11.45%
OTHER	VIVITROL	11.45%
OTHER	XERMELO	13.54%
OTHER	XGEVA	11.45%
OTHER	XIAFLEX	11.45%
OTHER	XYREM	13.54%
OTHER - IMMUNOMODULATOR	AZASAN	13.54%
OTHER - IMMUNOMODULATOR	IMURAN	13.54%
OTHER - IMMUNOMODULATOR	OTREXUP	11.45%
OTHER - IMMUNOMODULATOR	RASUVO	11.45%
OTHER - IMMUNOMODULATOR	THERACYS	11.45%
OTHER - IMMUNOMODULATOR	TREXALL	13.54%
PARKINSON'S DISEASE	APOKYN	11.45%
PARKINSON'S DISEASE	DUOPA	11.45%
PROTEIN C DEFICIENCY	CEPROTIN	11.45%
PSORIASIS	COSENTYX	10.00%
PULMONARY ARTERIAL HYPERTENSION	ADCIRCA	13.54%
PULMONARY ARTERIAL HYPERTENSION	ADEMPAS	13.54%
PULMONARY ARTERIAL HYPERTENSION	FLOLAN	11.45%
PULMONARY ARTERIAL HYPERTENSION	LETAIRIS	11.45%
PULMONARY ARTERIAL HYPERTENSION	OPSUMIT	13.54%
PULMONARY ARTERIAL HYPERTENSION	ORENITRAM	13.54%
PULMONARY ARTERIAL HYPERTENSION	REMODULIN	11.45%
PULMONARY ARTERIAL HYPERTENSION	REVATIO	11.45%
PULMONARY ARTERIAL HYPERTENSION	TRACLEER	11.46%
PULMONARY ARTERIAL HYPERTENSION	TYVASO	11.45%
PULMONARY ARTERIAL HYPERTENSION	UPTRAVI	13.54%
PULMONARY ARTERIAL HYPERTENSION	VELETRI	11.45%

PULMONARY ARTERIAL HYPERTENSION	VENTAVIS	6.25%
RA	ACTEMRA	11.45%
RA	KINERET	11.45%
RA	ORENCIA	11.45%
RA	XELJANZ	13.54%
RA/IBD	CIMZIA	11.45%
RA/JIA/PSOA/AS/PSORIASIS	ENBREL	11.45%
RA/JIA/PSOA/AS/PSORIASIS	ENTYVIO	11.45%
RA/JIA/PSOA/AS/PSORIASIS	OTEZLA	13.54%
RA/JIA/PSOA/AS/PSORIASIS/IBD	HUMIRA	11.45%
RA/JIA/PSOA/AS/PSORIASIS/IBD	INFLECTRA	11.45%
RA/PSOA/AS	SIMPONI	11.45%
RA/PSOA/AS/PSORIASIS/IBD	REMICADE	14.50%
RESPIRATORY SYNCYTIAL VIRUS	SYNAGIS	12.50%
RHO(D) IMMUNE GLOBULIN	HYPERRHO	11.45%
RHO(D) IMMUNE GLOBULIN	HYPERRHO S-D	11.45%
RHO(D) IMMUNE GLOBULIN	MICRHOGAM	11.45%
RHO(D) IMMUNE GLOBULIN	RHOGAM	11.45%
RHO(D) IMMUNE GLOBULIN	RHOGAM PLUS	11.45%
RHO(D) IMMUNE GLOBULIN	RHOPHYLAC	11.45%
RHO(D) IMMUNE GLOBULIN	WINRHO	11.45%
SPINAL MUSCULAR ATROPHY	SPINRAZA	11.45%
SYSTEMIC LUPUS ERYTHEMATOSUS	BENLYSTA	11.45%
TRANSPLANT	ASTAGRAF XL	13.54%
TRANSPLANT	ATGAM	11.45%
TRANSPLANT	CELLCEPT	13.54%
TRANSPLANT	ENVARSUS	13.54%
TRANSPLANT	KEPIVANCE	11.45%
TRANSPLANT	MYFORTIC	13.54%
TRANSPLANT	NEORAL	13.54%
TRANSPLANT	NULOJIX	11.45%
TRANSPLANT	PROGRAF	13.54%
TRANSPLANT	RAPAMUNE	13.54%
TRANSPLANT	SANDIMMUNE	11.45%
TRANSPLANT	SIMULECT	11.45%
TRANSPLANT	THYMOGLOBULIN	11.45%
TRANSPLANT	ZORTRESS	13.54%

VENO-OCCLUSIVE DISEASE	DEFITELIO	11.45%

Specialty Drug List Cigna HOME DELIVERY AND RETAIL SPECIALTY DRUG DISCOUNTS For Generic drugs as of 4/1/2017		
CONDITION	**BRAND NAME**	**AVERAGE AWP DISCOUNT**
ALS	RILUZOLE	83.50%
ANTI-COAGULANT	ARGATROBAN	40.00%
ANTI-INFECTIVE	CIDOFOVIR	40.00%
ANTI-INFECTIVE	GANCICLOVIR	40.00%
ANTI-INFECTIVE	TOBRAMYCIN	32.00%
CANCER - ANCILLARY/ADJUVANT	AMIFOSTINE	40.00%
CANCER - ANCILLARY/ADJUVANT	APREPITANT	29.80%
CANCER - ANCILLARY/ADJUVANT	LEUCOVORIN	16.60%
CANCER - ANCILLARY/ADJUVANT	LEUPROLIDE	53.70%
CANCER - ANCILLARY/ADJUVANT	LEVOLEUCOVORIN	11.45%
CANCER - ANCILLARY/ADJUVANT	MESNA	40.00%
CANCER - CHEMOTHERAPY	ADRIAMYCIN	15.00%
CANCER - CHEMOTHERAPY	ADRUCIL	14.00%
CANCER - CHEMOTHERAPY	ANAGRELIDE HCL	94.90%
CANCER - CHEMOTHERAPY	AZACITIDINE	16.71%
CANCER - CHEMOTHERAPY	BCG VACCINE (TICE STRAIN)	40.00%
CANCER - CHEMOTHERAPY	BEVACIZUMAB	17.00%
CANCER - CHEMOTHERAPY	BEXAROTENE	19.90%
CANCER - CHEMOTHERAPY	BICALUTAMIDE	93.60%
CANCER - CHEMOTHERAPY	BLEO	13.61%
CANCER - CHEMOTHERAPY	BLEOMYCIN SULFATE	13.61%
CANCER - CHEMOTHERAPY	CAPECITABINE	19.90%
CANCER - CHEMOTHERAPY	CARBOPLATIN	11.00%
CANCER - CHEMOTHERAPY	CISPLATIN	1.10%
CANCER - CHEMOTHERAPY	CLADRIBINE	16.66%
CANCER - CHEMOTHERAPY	CYCLOPHOSPHAMIDE	40.00%
CANCER - CHEMOTHERAPY	CYTARABINE	6.05%
CANCER - CHEMOTHERAPY	DACARBAZINE	40.00%
CANCER - CHEMOTHERAPY	DAUNORUBICIN HCL	40.00%
CANCER - CHEMOTHERAPY	DECITABINE	21.00%
CANCER - CHEMOTHERAPY	DOCETAXEL	21.00%
CANCER - CHEMOTHERAPY	DOXORUBICIN	15.00%

CANCER - CHEMOTHERAPY	EPIRUBICIN	40.00%
CANCER - CHEMOTHERAPY	ETOPOSIDE	25.30%
CANCER - CHEMOTHERAPY	FLOXURIDINE	40.00%
CANCER - CHEMOTHERAPY	FLUDARABINE	40.00%
CANCER - CHEMOTHERAPY	FLUDARABINE PHOSPHATE	40.00%
CANCER - CHEMOTHERAPY	FLUOROURACIL	16.66%
CANCER - CHEMOTHERAPY	FLUTAMIDE	38.70%
CANCER - CHEMOTHERAPY	GEMCITABINE	40.00%
CANCER - CHEMOTHERAPY	GLEEVEC	36.40%
CANCER - CHEMOTHERAPY	HYCAMTIN	40.00%
CANCER - CHEMOTHERAPY	IDARUBICIN HCL	40.00%
CANCER - CHEMOTHERAPY	IFOSFAMIDE	40.00%
CANCER - CHEMOTHERAPY	IMATINIB	28.00%
CANCER - CHEMOTHERAPY	IRINOTECAN	21.00%
CANCER - CHEMOTHERAPY	LIPODOX	21.00%
CANCER - CHEMOTHERAPY	LIPODOX 50	21.00%
CANCER - CHEMOTHERAPY	MELPHALAN	40.00%
CANCER - CHEMOTHERAPY	METHOTREXATE	16.50%
CANCER - CHEMOTHERAPY	MITOMYCIN	11.45%
CANCER - CHEMOTHERAPY	MITOXANTRONE HCL	40.00%
CANCER - CHEMOTHERAPY	OXALIPLATIN	16.66%
CANCER - CHEMOTHERAPY	PACLITAXEL	11.00%
CANCER - CHEMOTHERAPY	PENTOSTATIN	40.00%
CANCER - CHEMOTHERAPY	TEMOZOLOMIDE	26.20%
CANCER - CHEMOTHERAPY	TENIPOSIDE	40.00%
CANCER - CHEMOTHERAPY	THIOTEPA	40.00%
CANCER - CHEMOTHERAPY	TOPOSAR	25.30%
CANCER - CHEMOTHERAPY	TOPOTECAN	40.00%
CANCER - CHEMOTHERAPY	VANDETANIB	40.00%
CANCER - CHEMOTHERAPY	VINBLASTINE	40.00%
CANCER - CHEMOTHERAPY	VINCASAR	11.98%
CANCER - CHEMOTHERAPY	VINCRISTINE	11.98%
CANCER - CHEMOTHERAPY	VINORELBINE	40.00%
CANCER - CHEMOTHERAPY	ZELBORAF	20.00%
HEMOPHILIA	AMINOCAPROIC ACID	53.76%
HEMOPHILIA	TRANEXAMIC	21.80%
HEPATITIS B	ADEFOVIR DIPIVOXIL	17.40%

HEPATITIS B	ENTECAVIR	40.00%
HEPATITIS C	MODERIBA	90.10%
HEPATITIS C	RIBAPAK	47.80%
HEPATITIS C	RIBASPHERE	90.10%
HEPATITIS C	RIBAVIRIN	90.10%
HIV	ABACAVIR	17.00%
HIV	ABACAVIR-LAMIVUDINE	56.40%
HIV	ABACAVIR-LAMIVUDINE-ZIDOVUDINE	17.50%
HIV	DIDANOSINE	16.00%
HIV	LAMIVUDINE	16.00%
HIV	LAMIVUDINE-ZIDOVUDINE	28.20%
HIV	LOPINAVIR-RITONAVIR	26.20%
HIV	NEVIRAPINE	22.50%
HIV	STAVUDINE	57.90%
HIV	ZIDOVUDINE	18.60%
HYPERCALCEMIA	ZOLEDRONIC ACID	15.00%
HYPERPARATHYROIDISM	PARICALCITOL	17.60%
INFERTILITY	CHORIONIC GONADOTROPIN	20.30%
INFERTILITY	GANIRELIX ACETATE	12.30%
IVIG	GAMMAPLEX	40.00%
IVIG	PRIVIGEN	40.00%
MULTIPLE SCLEROSIS	EXTAVIA	11.45%
MULTIPLE SCLEROSIS	GLATOPA	37.10%
MUSCULAR/MOVEMENT	TETRABENAZINE	20.40%
OTHER	DESMOPRESSIN	15.00%
OTHER	ENOXAPARIN SODIUM	32.90%
OTHER	EUFLEXXA	17.00%
OTHER	FONDAPARINUX	16.00%
OTHER	GEL-ONE	9.40%
OTHER	IBANDRONATE	37.50%
OTHER	OCTREOTIDE	15.00%
OTHER	PAMIDRONATE	40.00%
OTHER	PROVISC	19.09%
OTHER	ZOLEDRONIC	35.40%
OTHER - IMMUNOMODULATOR	AZATHIOPRINE	56.50%
PULMONARY ARTERIAL HYPERTENSION	EPOPROSTENOL SODIUM	40.00%
PULMONARY ARTERIAL HYPERTENSION	SILDENAFIL	91.00%

TRANSPLANT	CYCLOSPORINE	17.10%
TRANSPLANT	GENGRAF	25.80%
TRANSPLANT	HECORIA	22.80%
TRANSPLANT	MYCOPHENOLATE	66.70%
TRANSPLANT	MYCOPHENOLIC ACID	19.60%
TRANSPLANT	SIROLIMUS	16.80%
TRANSPLANT	TACROLIMUS	22.80%

change in the Plan or the Plan's Pharmacy Benefit that is initiated by Employer which impacts CHLIC's costs.

New-to-Market Specialty Products. Specialty Drug Claims that are for new-to-market drugs will have a minimum market-introduction guaranteed discount of 11.45% off the drug's AWP.

***IMPORTANT NOTICE**: The stop-loss insurance policy in this PDF (the "Policy") has been validly issued by Cigna Health and Life Insurance Company in the state identified in the Coverage Information section of the Policy (the "Policy Issuance State") and shall be governed by its laws. For your convenience, the Policy is hereby transmitted electronically to you, as representative of the policyholder, in lieu of physical delivery of a paper copy of the Policy in the Policy Issuance State. Your receipt of this electronic transmission constitutes official delivery of the Policy in the Policy Issuance State no less than if a paper copy of the Policy were physically delivered at a policyholder address in the Policy Issuance State. If you prefer, a paper copy of the Policy will be delivered to a policyholder address that you identify in the Policy Issuance State.*

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')

Stop Loss Policy

Based on the application for this policy made by City of Santa Fe (herein called the Policyholder) and based on the payment of the premium when due, Cigna agrees to reimburse the Policyholder for Covered Expenses under the terms of this policy.

This policy becomes effective at 12:01 a.m. at the Policyholder's address on the Effective Date shown in the Coverage Information section.

All matter printed or written by Cigna on the following pages forms a part of this policy as if recited over the signatures below.

This policy is delivered in and is governed by the laws of the jurisdiction shown in the Coverage Information section.

The Policyholder has the right to examine this policy. As directed by the New Mexico Superintendent of Insurance, this policy is subject to a 10-day free look period. Read this policy carefully.

In witness thereof, Cigna has caused this policy to be executed at its home office in Bloomfield, Connecticut.

Assistant Secretary

Edward P. Potanka, Assistant Secretary

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')

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CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')
Definitions

Actual Attachment Point
Actual Attachment Point means the amount of Actual Claim Payments above which aggregate stop loss benefits are payable.

The Actual Attachment Point is determined at the end of the Policy Year and is the greater of: (1) the sum of all Policy Months in the Policy Year of the number of Covered Persons enrolled during each Lagged Month in each product and plan design in the Benefit Plan multiplied by the Monthly Attachment Factors for that Policy Month; or (2) the sum of the Minimum Attachment Point for each Policy Month.

For those policies with Run-Out coverage, in the year of termination the Actual Attachment Point is the sum of the product as calculated in accordance with the above paragraph plus the Run-Out Period Attachment Point.

Actual Claim Payment
Actual Claim Payment means a payment made on behalf of the Policyholder for a Covered Person under the terms of the Benefit Plan. A payment is deemed to have been made as of the date the payment instrument is issued by the Claim Administrator. An Actual Claim Payment does not include a claim payment made in error on behalf of a Covered Person.

Aggregate Individual Stop Loss Limit
Aggregate Individual Stop Loss Limit means the limit that must be met before benefits are payable for Aggregate Stop Loss coverage.

Aggregate Stop Loss Benefit Percentage Payable
Aggregate Stop Loss Benefit Percentage Payable means the percentage of Covered Expenses payable to the Policyholder once the Actual Attachment Point has been reached.

Become Due
Become Due is the earliest date upon which: (a) the Policyholder or the Claim Administrator has received due proof of loss for which a claim is made under the terms of the Benefit Plan, provided such loss is covered under this policy as a Covered Expense; and (b) an Actual Claim Payment has been made.

Benefit Plan or Plan
Benefit Plan or Plan means the Policyholder's medical benefits and/or other health benefits applicable to either the Individual Stop Loss benefit and/or the Aggregate Stop Loss benefit as uniquely specified for each benefit in the Schedule of Insurance.

Claim Administrator
Claim Administrator means Cigna or an entity approved by Cigna to provide administrative services and to pay claims for the Policyholder's Benefit Plan.

Corridor Factor
Corridor means the risk retained by the Policyholder. It is expressed as a percentage of Expected Paid Claims and is specified in the Schedule of Insurance.

CIGNA HEALTH AND LIFE INSURANCE COMPANY (Herein called 'Cigna')

Covered Expenses
Covered Expenses for a Policy Year are expenses made under the Benefit Plan that are reimbursable under this policy based on the criteria specified in the Schedule of Insurance.

Covered Person
Covered Person means a person who is enrolled for coverage and meets the eligibility requirements set forth in the Benefit Plan.

Effective Date
Effective Date means the date on which coverage begins under this agreement.

Expected Paid Claims
Expected Paid Claims means the projected claims at the time of the presale or renewal quote to be paid for all Covered Persons during the Policy Year.

High Risk Individual
High Risk Individual means a Covered Person whose claims under the Benefit Plan are expected to exceed the Individual Stop Loss Limit. For such person(s), a separate Individual Stop Loss Limit for High Risk Individuals is applicable, or such person may be excluded from coverage under this policy.

Incurred
Incurred means the date on which the supply is obtained or the service is rendered to a Covered Person under the Benefit Plan.

Individual Stop Loss Limit
Individual Stop Loss Limit means the specific dollar amount of Covered Expenses paid by the Policyholder for each Covered Person during each Policy Year, as set forth in the Schedule of Insurance. If coverage is terminated during any Policy Year, the Individual Stop Loss Limit will be the same as if the coverage had remained in effect for the entire Policy Year.

Individual Stop Loss Limit for High Risk Individuals
Individual Stop Loss Limit for High Risk Individuals means the specific dollar amount of Covered Expenses paid by the Policyholder for each High Risk Individual during each Policy Year, as set forth in the Schedule of Insurance. If coverage is terminated during any Policy Year, the Individual Stop Loss Limit for High Risk Individuals will be the same as if the coverage had remained in effect for the entire Policy Year.

Individual Stop Loss Benefit Percentage Payable
Individual Stop Loss Benefit Percentage Payable means the percentage of Covered Expenses payable to the Policyholder once the Individual Stop Loss Limit has been reached.

Lagged Month
Lagged Month is defined on the Schedule of Insurance as either the same as the current Policy Month or as the Policy Month one or more months prior to the corresponding Policy Month. In the event the Lagged Month refers to a month prior to the Effective Date of the policy, the Lagged Month is defined as the first Policy Month.

Minimum Attachment Exposure
Minimum Attachment Exposure is the greater of the number of Covered Persons enrolled during the Minimum Attachment Lagged Month in each product and plan design in the Benefit Plan; or the original estimated number of Covered Persons at the time of underwriting.

Minimum Attachment Lagged Month
Minimum Attachment Lagged Month is defined on the Schedule of Insurance as either the same as the Policy Year's first Policy Month or one or more months prior to the Policy Year's first Policy Month. In the event the Minimum Attachment Lagged Month refers to a month prior to the Effective Date of the policy, the Minimum Attachment Lagged Month is defined as the Policy Year's first Policy Month.

Minimum Attachment Percentage
The Minimum Attachment Percentage is used in computing the Minimum Attachment Point, and if applicable, the Minimum Run-Out Period Attachment Point. This percentage is shown on Schedule of Insurance.

Minimum Attachment Point
The Minimum Attachment Point is either not applicable (in which case it is assumed to have a value of zero in any calculation), or for each Policy Month and for each product and plan design, it is equal to the Minimum Attachment Percentage multiplied by the Minimum Attachment Exposure multiplied by Monthly Attachment Factors for the Policy Month.

Minimum Run-Out Period Attachment Point
The Minimum Run-Out Period Attachment Point is the Minimum Attachment Percentage multiplied by the Minimum Attachment Exposure multiplied by the sum of the Terminal Attachment Factors for each month as shown on the Schedule of Insurance under Terminal Attachment Factors.

Monthly Attachment Factor
Monthly Attachment Factor is a factor assigned to this policy to be used to calculate the Actual Attachment Point and Minimum Attachment Point, as applicable. This factor is shown on the Schedule of Insurance.

Policy Month
Policy Month means a calendar month during a Policy Year.

Policy Quarter
Policy Quarter means a period of three consecutive calendar months during a Policy Year, with the first Policy Quarter beginning on the Effective Date of the policy.

Policy Year
Policy Year means the period beginning on the Effective Date of this policy (or most recent Renewal Date thereof) up to but not including the next renewal date or the date of termination, whichever period is shorter. The Policy Year is specified on the Schedule of Insurance and may differ by coverage as indicated on the Schedule of Insurance.

CIGNA HEALTH AND LIFE INSURANCE COMPANY (Herein called 'Cigna')

Renewal Date
Renewal Date is the day on which a new Policy Year begins as specified on the Schedule of Insurance.

Run-Out Period
Run-Out Period is the length of time following the termination date of this policy during which claims that Become Due for a Covered Person under the Benefit Plan will accumulate toward stop loss coverage under this policy provided that they were Incurred prior to the termination date of this policy.

Run-Out Period Attachment Point
Run-Out Period Attachment Point is the greater of the Minimum Run-Out Period Attachment Point or the sum of each product in the Benefit Plan and each month (as shown on the Schedule of Insurance under Terminal Attachment Factors) of the Terminal Attachment Factor multiplied by the number of Covered Persons enrolled during the respective Lagged Month for that month.

Terminal Attachment Factor
Terminal Attachment Factor is a factor assigned to this policy to be used to calculate the Run-Out Period Attachment Point and the Minimum Run-Out Period Attachment Point. This factor is shown on the Schedule of Insurance.

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')
Benefit Provisions

Individual Stop Loss Coverage

In consideration of payment of the Individual Stop Loss premium by the Policyholder, Cigna shall reimburse the Policyholder for the amount by which the total Covered Expenses for the Policy Year for a Covered Person exceed the Individual Stop Loss Limit. The amount of reimbursement will be calculated by multiplying the amount of Covered Expenses in excess of the Individual Stop Loss Limit times the Individual Stop Loss Benefit Percentage Payable, subject to Cigna's maximum liability specified on the Schedule of Insurance.

Reimbursement for Covered Expenses will be made after an Actual Claim Payment is made.

Cigna shall not be liable for any expenses that are Incurred or Become Due outside the term of this policy.

Other
If Cigna is not the Claim Administrator, payment for Covered Expenses will be made after receipt and acceptance by Cigna of such information and records as Cigna may reasonably require regarding the Actual Claim Payments.

Aggregate Stop Loss Coverage

In consideration of payment of the Aggregate Stop Loss premium by the Policyholder, Cigna shall reimburse the Policyholder for Covered Expenses for the Policy Year that are in excess of the Actual Attachment Point. The amount of reimbursement will be calculated by multiplying the amount of Covered Expenses in excess of the Actual Attachment Point times the Aggregate Stop Loss Benefit Percentage Payable, subject to Cigna's maximum liability specified on the Schedule of Insurance.

Covered Expenses paid by the Policyholder in excess of the Aggregate Individual Stop Loss Limit are excluded prior to determining if the Actual Attachment Point is reached.

For the purpose of this calculation, amounts between the Aggregate Individual Stop Loss Limit and the Individual Stop Loss Limit for High Risk Individuals are also excluded.

The above payments, reimbursements and credits made by Cigna to the Policyholder are subject to Cigna's maximum liability specified on the Schedule of Insurance.

Cigna shall not be liable for any expenses that are Incurred or Become Due outside the term of this policy.

Other
If Cigna is not the Claim Administrator, payment for Covered Expenses will be made after receipt and acceptance by Cigna of such information and records as Cigna may reasonably require regarding the Actual Claim Payments.

In the event Cigna is the Claim Administrator paying claims out of the Policyholder's bank account established for the purpose of paying claims and such bank account is still open and available to Cigna, any payments or reimbursements under this benefit will be executed by Cigna debiting or crediting the Policyholder's bank account.

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')
Duties of the Policyholder

A. The Policyholder will submit to Cigna a complete copy of the Benefit Plan unless Cigna already has such copy in its possession; such Benefit Plan or its complete copy is incorporated herein by reference.

B. Any changes to the Benefit Plan will be submitted to Cigna 60 days prior to their Effective Date.

C. If Cigna is not the Claim Administrator, the parties agree that the Policyholder or the Claim Administrator approved by Cigna will have the following duties and obligations:

1. to investigate, audit, calculate and pay all claims in accordance with the provisions of the Benefit Plan and any applicable provider contracts.

2. to provide Cigna such information and records that Cigna may reasonably require for:

   a. payment of any claim under this policy; and
   b. projection of future expected claims of the Benefit Plan.

3. to prepare and submit to Cigna on a monthly basis:

   a. a report of the Actual Claim Payments paid pursuant to the Benefit Plan for that month;
   b. a report of the total number of Covered Persons covered by the Benefit Plan for that month; and
   c. a report listing claimants with Covered Expenses during the Policy Year greater than 50% of the Individual Stop Loss Limit. The listing is to include cumulative paid claims and the respective ICD-9 codes.

4. for Individual Stop Loss, the preparation and submission to Cigna on a monthly basis, within 15 days of the previous month's end, of a report showing Covered Expenses during the month for those Covered Persons for whom the total Covered Expenses for the stop loss Policy Year meet or exceed 50% of the Individual Stop Loss Limit; and a completed Stop Loss Notification form (to be supplied) which must accompany the report for each listed Covered Person.

5. for any and all Covered Persons whose Covered Expenses meet or exceed the Individual Stop Loss Limit during the Policy Year, the following information must be supplied for claim adjudication under this policy. This information must accompany a Stop Loss Notification form and must be presented to Cigna within 30 days of the end of the month in which the Covered Person exceeded the Individual Stop Loss Limit:

   a. copies of any and all documentation relating to outside bill reviews/negotiations for hospital bills greater than $15,000 and other provider bills greater than $2,500;
   b. copies of any and all documentation relating to the Benefit Plan's subrogation interests, if applicable;
   c. detailed claim reports and check information if explanation of benefits (EOBs) are not available;
   d. itemized bills for any claims or charges over $5,000;
   e. an enrollment form or eligibility screen; and
   f. coordination of benefits (COB) information.

D. The Policyholder will reimburse Cigna for any Actual Claim Payments subsequently repaid, refunded, rebated or owed to the Policyholder by any party.

E. The Policyholder will furnish additional information or documentation as reasonably requested by Cigna.

CIGNA HEALTH AND LIFE INSURANCE COMPANY
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Exclusions

Covered Expenses under this policy do not include the following:

1. Actual Claim Payments for which (a) there is other group insurance (including costs recoverable through the application of the coordination of benefits provision in the Benefit Plan); (b) third-party liability has been established; (c) there is coverage pursuant to any plan established by federal, state or local law (to the extent permitted); or (d) there is coverage under workers compensation insurance.

2. Expenses to the extent the Policyholder or Plan receives any payment(s), refund(s) or rebate(s), however denominated, or any reduction in charges including but not limited to reductions as a result of a PPO, EPO, or other managed care arrangement, claim reduction negotiation, or the application of any provider discount arrangement.

3. Expenses which Become Due after the date coverage under this policy ceases.

4. Administrative expenses of the Policyholder or Claim Administrator.

5. Extra contractual damages, expenses or reimbursements of any kind or nature.

6. Investigative or legal expenses including, but not limited to, attorney fees and court costs.

7. Expenses Incurred by a person not eligible under the terms of the Benefit Plan.

8. Expenses paid because of an amendment to the Benefit Plan which is not agreed to by Cigna.

9. Unless indicated on the Schedule of Insurance, expenses for taxes, fees and surcharges that may be imposed on the Benefit Plan or Policyholder by federal, state or local governments.

10. Expenses Incurred as a result of war, whether declared or not, or acts of war or service in any military force of any country while such country is engaged in war, whether declared or not.

11. Expenses which are not considered Covered Expenses under the Benefit Plan.

12. Expenses for which the Policyholder or Claim Administrator has failed to provide the required information set forth under the Duties of the Policyholder section.

13. With respect to Individual Stop Loss, and with respect to Aggregate Stop Loss if indicated on the Schedule, expenses resulting from capitation payments, if any (i.e. contractually determined periodic payments to certain providers based on the number of Plan participants entitled to receive services from the provider, in return for which, such providers furnish certain agreed-upon services to eligible plan participants).

14. For liabilities which are non-pecuniary in nature (not having a monetary value).

Omission, Concealment or Misrepresentation of Fact

The parties understand that Cigna has relied upon the completeness and accuracy of the underwriting information presented to Cigna in its decision to issue and/or renew this policy. Such information includes information volunteered by the Policyholder when requesting the quote, information provided in response to a request by Cigna, and any personal health statements filled out by persons covered under the Benefit Plan. If Cigna determines that any of the information has omitted, concealed or misrepresented any fact which Cigna determines to have had an effect on Cigna's assessment of the risk, Cigna reserves the right to re-underwrite the coverage, including but not limited to resetting the premium rates, resetting the Individual Stop Loss Limits, resetting or establishing coverage maximums, resetting Monthly Attachment Factors, and minimum attachment factors; or Cigna may terminate this policy. Any such action by Cigna will be reasonable in relation to the nature of the omission, concealment, or misrepresentation, and may be retroactive to the beginning of the Policy Year.

Subrogation and Acts of Third Parties

Applicability
Where allowed by law, this section will apply:

1. to Policyholders who receive payments for Covered Expenses under this policy; and

2. where Actual Claim Payments have been made under the Benefit Plan to a Covered Person who has a lawful claim against, or who has received compensation, damages or other payment from another party or parties for expenses resulting in the payment by Cigna of such Covered Expenses; and

3. to the Policy Year in which the corresponding payment was made. The expense of subrogation will be shared proportional according to the Benefit Plan.

Policyholder Obligations
To secure the rights of Cigna under this section, the Policyholder must:

1. pursue the rights of subrogation contained in the Benefit Plan; and

2. reimburse Cigna for Covered Expenses Incurred under this policy (but not more than the amount paid by the other party or parties) if payment from the other party or parties has been received by the Policyholder. The Policyholder must reimburse Cigna first, and in full, before retaining any benefit from the recovery; and

3. assign to Cigna the Policyholder's subrogation and/or reimbursement right contained in the Benefit Plan to the extent of Cigna's payments if requested by Cigna and Policyholder shall cooperate fully and do all things as necessary and required to enable Cigna to pursue the recovery right.

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')

Privacy of Information

In connection with the performance of its obligations under this policy, Cigna may disclose to and receive disclosure from the Policyholder or its Claim Administrator of information collected or received in connection with Covered Expenses reimbursable under this policy, provided the information is limited to that which is reasonable and necessary.

Under no circumstances will Cigna provide the Policyholder with information on Incurred, but not paid claims, projected claims, pre-certifications of coverage, case management notes, and course of treatment information or prognosis information.

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')

Premiums

Premium Payments
The initial premium shall be due and payable on the first day of the month of this policy. Subsequent premiums shall be due on the first day of each calendar month that this policy remains in effect.

Premiums can be paid to Cigna's home office or to an authorized agent of Cigna. Each premium paid continues the policy in force until the date the next premium is due, except as set forth in the Grace Period section.

The total monthly premium is the sum of the premium for all Covered Persons for all coverages as identified on the Schedule of Insurance.

Grace Period
A period of 31 days, without interest, is allowed for paying any premium other than the first premium payment due. The policy will remain in force during the grace period, unless Cigna has been advised in writing that the policy is to cease prior to the end of the grace period. If any premium is not paid before the grace period ends, the policy will cease at the end of the grace period. When this policy ends, the Policyholder will be liable for all premiums past due and unpaid, including a pro-rata premium for any time this policy remains in force during the grace period.

Premium Refund
Any error or correction of any premium paid must be reported to Cigna promptly. The premium will be adjusted retroactively to reflect the correct premium amount. If a correction will result in a decrease in premium, a refund will be given only for the two month period prior to Cigna's receipt of a correction request.

CIGNA HEALTH AND LIFE INSURANCE COMPANY (Herein called 'Cigna')

Right to Change Terms of Coverage

Cigna reserves the right to change any of the terms shown on the Schedule of Insurance including but not limited to the Individual Stop Loss Limits, the Monthly Attachment Factors, the Terminal Attachment Factors, Minimum Attachment Point and/or premium rates under the following circumstances:

1. In the event the total number of Covered Persons at the beginning of the Policy Year or at any time during the Policy year differs more than 10% from the original estimated enrollment, such change to become effective on the first day of any month following the fluctuation, however any increase in premium will be subject to advance written notice of at least 60 days.

2. In the event enrollment in any covered Plan at the beginning of the Policy Year or at any time during the Policy year differs more than 10% from the original estimated enrollment, such change to become effective on the first day of any month following the fluctuation, however any increase in premium will be subject to advance written notice of at least 60 days.

3. In the event of material changes in the Benefit Plan or changes in legislation or regulation, Cigna may revise the premium rates with the revision to become effective on the date such changes are effective.

4. In the event of the addition of a subsidiary, operation or class of Covered Persons not previously covered under the Benefit Plan and approved by Cigna, Cigna may revise the premium rates with the revision to become effective on the date such addition is effective.

5. In the event of the termination of a subsidiary, operation or class of Covered Persons covered under this policy, Cigna may revise the premium rates with the revision to become effective on the date such termination is effective.

6. On any policy anniversary, subject to advance written notice of at least 31 days, however any increase in premium will be subject to advance written notice of at least 60 days.

7. In the event of an omission, concealment or misrepresentation of material fact, as described in Omission, Concealment or Misrepresentation of Fact section, such change to become retroactively to the first day of the affected Policy Year.

If Cigna is not the Claim Administrator, Cigna also reserves the right to change any premium rates if Cigna determines that Actual Claim Payments are not being made in accordance with the provisions of the Benefit Plan. Such adjustment may be made retroactive to the beginning of the Policy Year.

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')

Termination

This policy will continue in effect from its Effective Date until terminated on the earliest of the following:

1. At the end of the grace period if the premium is not paid.

2. Upon mutual consent by the parties, on the date the parties agree to terminate.

3. On the premium due date following 31 days after the mailing of written notification of termination by Cigna or the Policyholder.

4. On the date of termination of the Benefit Plan.

5. If any state or other jurisdiction enacts a law which prohibits the continuance of this policy, or the existing law is interpreted to so prohibit the continuance of this policy, as reasonably determined by Cigna, the policy shall terminate automatically as to such time or jurisdiction on the effective date of such law or interpretation.

6. Immediately upon written notice to the Policyholder of the discovery of the Policyholder's failure to comply with any material term of the policy.

7. Immediately upon written notice to the Policyholder if Cigna reasonably determines that the Policyholder has ceased or failed to sufficiently fund its account established to fund benefit payments under the Plan.

This policy may also be terminated by Cigna as follows:

1. Retroactively to the Policy Effective Date or the latest Renewal Date as applicable, upon written notice to the Policyholder, if Cigna determines that any of the information has omitted, concealed or misrepresented any fact which Cigna determines to have had a material effect on Cigna's assessment of the risk.

2. On the next premium due date, at Cigna's option, if Cigna determines that Actual Claim Payments are not being made in accordance with the provisions of the Benefit Plan, subject to advance written notice of at least 45 days.

3. On the effective date of a change in the Benefit Plan which is not approved by Cigna. Cigna will give the Policyholder written notice within 31 days after receipt of a copy of such change, if the Policyholder notifies Cigna within sufficient time to allow compliance with this notice requirement.

4. On the effective date of any change in Claim Administrator which is not approved by Cigna. Cigna will give the Policyholder written notice within 31 days after receipt of notification of such change, if the Policyholder notifies Cigna within sufficient time to allow compliance with this notice requirement.

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')

All coverage ceases upon termination of this policy. The termination of this policy does not excuse the Policyholder from forwarding to Cigna any and all premiums accrued through the date of termination.

If the policy includes Run-Out coverage, Cigna reserves the right not to provide Run-Out coverage in the event of termination prior to the end of the Policy Year.

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')

General Provisions

Notice
This policy provides benefits when the Policyholder's Benefit Plan incurs expenses in excess of the individual and/or aggregate limits as outlined in this policy. Since this policy insures the Policyholder and not the individuals covered by the Policyholder's Benefit Plan, this policy neither adds to nor subtracts from the terms of the underlying Benefit Plan. Additionally, this policy does not in any way affect the Policyholder's responsibility to comply with employment laws such as the Americans with Disabilities Act, the Age Discrimination in Employment Act, Title VII of the 1964 Civil Rights Act and other applicable state and federal laws.

Parties to the Policy and Responsibility for Claims for Benefits by Covered Persons
The parties to the policy are the Policyholder and Cigna. There are no third party beneficiaries and this policy does not create any rights or legal relation whatsoever between Cigna and a Covered Person under the Policyholder's Benefit Plan. Cigna's sole liability under this policy is to the Policyholder.

The Policyholder shall retain the exclusive obligation for any action, brought for benefits under the Policyholder's Benefit Plan however denominated, including any action purporting to be brought with respect to this policy. Policyholder agrees to assume the tender of any such action and to reimburse Cigna for reasonable costs, costs of whatever kind (including court costs and attorney fees) which Cigna may incur to protect its and Policyholder's rights until Policyholder accepts tender. Provided that nothing herein shall alter Cigna's obligations contained in the parties' administrative services agreement, if any.

Entire Contract
The parties agree that this policy and any endorsement and amendment to the policy constitute the entire contract regarding the stop loss insurance between the parties. Any endorsement or amendment changing this policy must be in writing and must be signed by authorized officers of Cigna and the Policyholder respectively. No person may modify or waive any of the terms of this policy except by a written amendment signed by a duly authorized officer of Cigna.

Enforceability
In the event that one or more provisions in this policy shall, for any reason, be held to be invalid, illegal or unenforceable, the validity, legality or enforceability of the other provisions of this policy shall not be affected.

Clerical Error
Clerical error by the Policyholder or by Cigna will not continue terminated coverage. In the event of such clerical error, an appropriate adjustment will be made.

Upon learning of a clerical error in this policy, the policy will be revised and reissued by Cigna to correct the error and if premium or reimbursement is impacted, an adjustment will be made accordingly. A clerical error will not invalidate coverage otherwise validly in force or continue otherwise terminated coverage.

Examination and Maintenance of Records
If Cigna is not the Claim Administrator:

1. The Policyholder will furnish to Cigna such data as may be required for the administration of this policy.

2. The Policyholder's and the Claim Administrator's books and records pertaining to the policy will be available to Cigna for inspection during the usual business hours. Such books and records will be maintained for a period of not less than 6 years following termination of the policy.

3. Cigna will have the right at all reasonable times to inspect all records relating to Actual Claim Payments paid under the Benefit Plan whether maintained by the Policyholder or the Claim Administrator. Cigna will treat as confidential all such records and information obtained.

Dispute Resolution
It is understood and agreed that any dispute, controversy or question arising from or relating to the performance or interpretation of this policy, the breach thereof, or the subject matter thereof (controversy) shall be resolved exclusively pursuant to the following mandatory Dispute Resolution procedures, provided however that the Policyholder may not initiate any dispute resolution relating to a claim under this policy fewer than 60 calendar days or more than three years after due proof of such claim is furnished to Cigna:

1. Any controversy between the parties arising shall first be referred for executive review. The disputing party shall initiate executive review by giving the other party written notice of the controversy, and shall specifically request executive review of said controversy in such notice. Within 20 calendar days of any party's written request for executive review, the receiving party shall submit a written response. Both the notice and response shall include a statement of each party's position and a summary of the evidence and arguments supporting its position. Within 30 calendar days of any party's request for executive review, an executive level employee of each party shall be designated by the party to meet and confer with his/her counterpart to attempt to resolve the controversy.

2. In the event that a controversy has not been resolved within 35 calendar days of the request of executive review under Section 1 above, the disputing party shall initiate mediation by providing written notice to the other party, which shall be conducted in such location or locations determined by the mediator in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Mediation. Each party shall assume its own costs and attorney fees, and the compensation and expenses of the mediator and any administrative fees or costs shall be borne equally by the parties.

3. In the event that a controversy has not been resolved within 60 calendar days of the request for mediation under Section 2 above, the controversy shall be settled exclusively by binding arbitration. The arbitration shall be conducted in such location or locations determined by the arbitrator in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration, and which to the extent of the subject matter of the arbitration, shall be binding not only on all parties to the agreement, but on any other entity controlled by, in control of or under common control with the party to the extent that such affiliate joins in the arbitration, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Each party shall assume its own costs and attorney fees, and the compensation and expenses of the mediator and any administrative fees or costs shall be borne equally by the parties. The decision of the arbitrator shall be final, conclusive and binding, and no action at law or in equity may be instituted by either party other than to enforce the award of the arbitrator.

This provision shall survive the termination of this policy.

Plan Changes
Cigna must approve a change in the Benefit Plan if the change impacts the Covered Expense under this policy. The Policyholder must promptly furnish Cigna with a copy of each change in the Benefit Plan prior to its effective date. If such copy is not received, Cigna will only be liable for the reimbursement of Covered Expenses under this policy as if the Plan was not changed.

Subcontracting
The work to be performed by Cigna under this policy may be performed wholly or in part through an authorized representative, subsidiary, affiliate, or parent of Cigna. Such subcontracting will not increase or diminish the rights or obligations of either party to this policy.

Assignment
No assignment of this policy by the Policyholder will be binding upon Cigna.

Offset
Cigna shall be entitled to offset payments due to the Policyholder under this policy against premiums due and unpaid by the Policyholder to Cigna.

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')
Schedule of Insurance

Coverage Information

Policyholder:	City of Santa Fe
Policy Number:	3338881
Effective Date:	July 01, 2017
Issue Date:	July 28, 2017
Next Renewal Date:	July 01, 2018
State or other Jurisdiction of Issue:	New Mexico

Notices

For the purpose of any notices required under this policy, such notices should be sent to the addresses shown below:

Cigna Health and Life Insurance Company
900 Cottage Grove Road, Hartford, CT 06152
Attn: Stop Loss Unit

City of Santa Fe
200 Lincoln Ave
Sante Fe, NM 87501
Attn: Vicki Gage
vlgage@santafenm.gov
505-995-6595

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')

Individual Stop Loss Coverage

Policy Year: July 01, 2017 to June 30, 2018

Covered Expenses: Claims that are Incurred between July 01, 2014 and June 30, 2018 and that Become Due between July 01, 2017 and June 30, 2018

Monthly Premium Rates:
For each covered employee $74.00

Individual Stop Loss Benefit Percentage Payable: 100%

Individual Stop Loss Limit: $250,000.00

The following Covered Persons have been identified as High Risk Individuals and shall be subject to the Individual Stop Loss Limit as specified below:

High Risk Individuals None

Benefit Plans Covered by Individual Stop Loss Coverage:

Claim Administrator	Product
Cigna	HRA Open Access Plus Plan
Cigna	Mental Health/Substance Use Disorders
Cigna	Open Access Plus Plan
Cigna	Open Access Plus Premium Plan
Cigna	Pharmacy Expense

Cigna's maximum liability per individual: Will be the individual maximum, if any, as set forth in the Benefit Plan less the Individual Stop Loss Limit

Additional exclusions from Individual Stop Loss coverage under this policy:

- Funds contributed by the company or an employee as part of a Health Reimbursement Account, Health Savings Account or Flexible Spending Account.
- All Retirees

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')

Aggregate Stop Loss Coverage

Policy Year: July 01, 2017 to June 30, 2018

Covered Expenses: Claims that are Incurred between July 01, 2014 and June 30, 2018 and that Become Due between July 01, 2017 and June 30, 2018

For purposes of Aggregate Stop Loss, amounts attributable to claim base state surcharges and/or the New York Covered Lives Assessment, as applicable, shall not be considered to be an excluded expenses of the Policyholder or Claim Administrator and as such shall be considered Covered Expenses.

Monthly Premium Rates:
For each covered employee $4.93

Aggregate Stop Loss Benefit Percentage Payable: 100%

Aggregate Individual Stop Loss Limit: $250,000.00

Benefit Plans Covered by Aggregate Stop Loss Coverage:

Claim Administrator	Product
Cigna	HRA Open Access Plus Plan
Cigna	Mental Health/Substance Use Disorders
Cigna	Open Access Plus Plan
Cigna	Open Access Plus Premium Plan
Cigna	Pharmacy Expense

Cigna's maximum liability for the Aggregate Stop Loss coverage: Unlimited for the Policy Year

Corridor Factor: 125%

Minimum Attachment Point: $24,031,675.40

Minimum Attachment Percentage: 100%

Minimum Attachment Lagged Month: Two Months prior to the Policy Year's first Policy Month

Lagged Month: Two Months Prior

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')

Monthly Attachment Factor (for each Covered Person):

Claim Administrator	Product	
Cigna	HRA Open Access Plus Plan	$1,181.83
Cigna	Open Access Plus Core Plan	$1,512.99
Cigna	Open Access Plus Premium Plan	$1,643.66

Additional exclusions from Aggregate Stop Loss Coverage:

- Funds, if any, contributed by the company or an employee as part of a Health Reimbursement Account, Health Savings Account or Flexible Spending Account.
- All Retirees

Payment of premium is considered acceptance of this policy and the terms within.

Contractual Agreements Unit
Underwriting
Cigna

Routing B2CAU
900 Cottage Grove Road
Hartford, CT 06152

July 2, 2018

Lynette Trujillo
Director, Human Resources
City of Santa Fe
200 Lincoln Avenue
Santa Fe, NM 87501

RE: 2018 Plan Year Services and Charges (Effective July 1, 2018)

Account Name: City of Santa Fe

Account Number(s): 3338881

Dear Ms. Trujillo:

Cigna Health and Life Insurance Company ("**CHLIC**") wants you to be aware of the services provided and charges that may be made by CHLIC and its affiliates in connection with the administration of your plan. Enclosed is a summary of the services for which you may be charged in connection with your Administrative Service Agreement with CHLIC Life Insurance Company.

The summary identifies the services that may apply to plans administered by CHLIC. Some specific services may not apply to your plan. Where a specific charge is identified, it is the charge in effect currently. Most charges are subject to change. To determine the current charge for any particular services in the future or for prior periods, contact your Cigna HealthCare sales representative.

If you have any other questions, please call your group sales representative.

Underwriting Contractual Agreements Unit

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SERVICES

I.Charges Processed Through Bank Account

Integrated Medical Management Fees

Charges may be processed through your bank account or directly billed to you as part of your Network Access Fee.

Your Health First

Charges may be processed through your bank account or directly billed to you as part of your Network Access Fee.

Your Health First is a disease management program that provides education, support and tools to help patient participants manage their conditions, support learning and reinforce positive self care behaviors, including: customized counseling by phone from a clinician, and educational materials appropriate to their specific diagnosis.

Cigna Behavioral Health

Charges may be processed through your bank account or directly billed to you as part of your Network Access Fee.

If behavioral health services are provided/arranged by Cigna Behavioral Health (CBH), CBH provides utilization review and case management for inpatient and outpatient, in-network behavioral health services. [OAP/ HRA OAP Medical Products Only]

Cigna Staff Model Healthplan(s)

The Cigna HealthCare of Arizona, Inc. staff model ("**Cigna Medical Group**") is a Participating Provider located in metropolitan Phoenix, Arizona. Plan Participants may at some time receive treatment from a Cigna Medical Group ("**CMG**") facility or provider even if they do not reside in Arizona (as when traveling). Plan Participants utilizing the independent practice network ("**IPN**") will access certain specialty and/or ancillary services (including laboratory and urgent care services) through the CMG system. Lab services are not provided by CMG for Participants in PPO or EPO plans.

Except as provided below, for covered services provided to Participants, CMG is paid at the rates in effect at the time of service (as may be revised from time to time). Representative rates for routinely performed services are attached. A complete copy of the rates is available on request under a mutually agreed nondisclosure agreement ("**NDA**").

If the Plan requires Participants to select a primary care provider ("**PCP**"), Phoenix area Participants who do not select a PCP during open enrollment may be assigned to a CMG PCP. CMG is paid for primary care services at the rates in effect at the time of service.

CMG may also receive applicable performance-based incentive payments for its participation in programs designed to improve quality, patient safety and affordability.

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Schedule of Financial Charges

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

MEDICAL/DENTAL ADMINISTRATION CHARGES		
Product	**Description**	**Charge**
Medical	• Open Access Plus (OAP) with Care Management Preferred	**$40.45/employee/month**
Medical	• HRA Open Access Plus (OAP) with Care Management Preferred	**$45.59/employee/month**
Dental	• Dental Preferred Provider Organization (DPPO)	**$3.59/employee/month**

MEDICAL/DENTAL NETWORK ACCESS FEE, UTILIZATION MANAGEMENT FEE AND OPTIONAL PROGRAM FEE		
Product	**Description**	**Charge**
Medical	• OAP Access Fee	**$23.67/employee/month Included in Medical Administration Charge**
Medical	• HRA OAP Access Fee	**$23.67/employee/month Included in Medical Administration Charge**
Dental	• DPPO Access Fee	**$0.84/employee/month Included in Dental Administration Charge**

CIGNA CHOICE FUND AND OTHER CONSUMER DIRECTED ACCOUNT ADMINISTRATION SERVICES AND CHARGES		
	Product	**Charge**
	• Cigna Choice Fund Health Reimbursement Account (HRA) Administration	**$5.14/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. • 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 • Support of Participants identified through predictive modeling with certain preference sensitive care conditions by supplying impartial evidence based medical information, to empower Participants' to understand the potential benefits/ disadvantages of a specific course of action and make more informed care decisions. • Answering health and medical related questions • Counseling Participants on prevention and the benefits of compliance with prescribed medications and treatments	**For HRA OAP Only: Included in Medical Access Fee**
	• Dependent Care Flexible Spending Account (DFSA) Administration	**Included at No Additional Cost**
	• Health Care Flexible Spending Account (FSA) Administration	**$5.79/employee/month**
AMOUNTS OWED TO CHLIC		
Amounts paid by CHLIC with its own funds on behalf of Employer or the Plan with respect to charges for which Employer or the Plan is obligated to pay under this Agreement including Plan Benefits, Bank Account Payments (including fixed per person payments and pay-for-performance payments to Participating Providers), governmental taxes or assessments.		

CIGNA PHARMACY BENEFIT MANAGEMENT SERVICES CHARGES AND RELATED PROVISIONS
PHARMACY ADMINISTRATION FEE
• Cigna Pharmacy Product Administration Fee, only if applicable, is separate from the Medical Administration Charge shown above, but included on same billing line as the Medical Administration Charge for billing purposes only.
CHARGES FOR COVERED DRUGS
Drugs Dispensed by Cigna Home Delivery Pharmacy: CHLIC will administer Claims for Covered Drugs dispensed to Members by Cigna Home Delivery Pharmacy based on the following charges, subject to the "PBM Pricing – Additional Provisions" section:
Brand Drug Claims: AWP minus an Actuarially Estimated average discount of 22.00%. **Generic Drug Claims:** The Generic Drug's charge on a CHLIC MAC List which generates an Actuarially Estimated average discount on Generic Drugs across those CHLIC clients in the aggregate using such MAC List of AWP minus 82.00%. **Specialty Drug Claims:** The Specialty Drug's charge discounted as shown in the Cigna Home Delivery Pharmacy Specialty Drug List, attached as Appendix B hereto. **Dispensing Fees for Both Brand Drug Claims and Generic Drug Claims:** An average Dispensing Fee of no more than $0.00.
Covered Drugs Dispensed by Retail Pharmacies in 30-day* supplies: CHLIC will administer Claims for 30-day supplies of Covered Drugs dispensed by a Retail Pharmacy based on the following charges, subject to the "PBM Pricing – Additional Provisions" section: ***A 30-day supply includes any Covered Drug dispensed by a Retail Pharmacy in an amount less than an 83-day supply.**
Brand Drug Claims: The lesser of (i) AWP minus an Actuarially Estimated average discount of 19.20%; or (ii) the Retail Pharmacy's U&C Charge. **Generic Drug Claims:** The lesser of: (i) the Generic Drug's charge on a CHLIC MAC List which generates an Actuarially Estimated average discount on Generic Drugs across those CHLIC clients in the aggregate using such MAC List of AWP minus 79.25%; or (ii) the Retail Pharmacy's U&C Charge. **Specialty Generic Drug Claims:** The Specialty Generic Drug's charge discounted as shown in the Specialty Drug List, attached as Appendix B hereto. **Specialty Brand Drug Claims:** The lesser of (i) AWP minus an Actuarially Estimated annual average aggregate discount of 11.50%; or (ii) the Retail Pharmacy's U&C Charge. **Dispensing Fees for Both Brand Drug Claims and Generic Drug Claims:** An Actuarially Estimated average Dispensing Fee of no more than $1.20, except in the case of Claims adjudicated at the U&C Charge, for which no separate Dispensing Fee is charged.

Covered Drugs Dispensed by Retail Pharmacies in 90-day supplies:** CHLIC will administer Claims for 90-day supplies of Covered Drugs dispensed by a Retail Pharmacy based on the following charges, subject to the "PBM Pricing – Additional Provisions" section:

****A 90-day supply includes any Covered Drug dispensed by a Retail Pharmacy in an amount equal to or greater than an 83-day supply.**

Brand Drug Claims: The lesser of (i) AWP minus an Actuarially Estimated average discount of 22.00%; or (ii) the Retail Pharmacy's U&C Charge.

Generic Drug Claims: The lesser of: (i) the Generic Drug's charge on a CHLIC MAC List that generates an Actuarially Estimated average discount on Generic Drugs across those CHLIC clients in the aggregate using such MAC List of AWP minus 83.00%; or (ii) the Retail Pharmacy's U&C Charge.

Specialty Generic Drug Claims: The Specialty Generic Drug's charge discounted as shown in the Specialty Drug List, attached as Appendix B hereto.

Specialty Brand Drug Claims: The lesser of (i) AWP minus an Actuarially Estimated annual average aggregate discount of 11.50%; or (ii) the Retail Pharmacy's U&C Charge.

Dispensing Fees for Both Brand Drug Claims and Generic Drug Claims: An average Dispensing Fee of no more than $0.00, except in the case of Claims adjudicated at the U&C Charge, for which no separate Dispensing Fee is charged.

PBM PRICING – ADDITIONAL PROVISIONS
• Cigna Home Delivery Pharmacy's discounts are applied to the manufacturer average wholesale price (AWP) for the dispensed size (or to the AWP for the manufacturer-packaged quantity closest to the dispensed size, if there is no AWP for the dispensed size). • The amount paid by CHLIC to the Retail Pharmacy for Claims for Covered Drugs may or may not be equal to the amount charged to Employer and/or Member, and CHLIC will absorb or retain any difference. • For a specific Claim for a Covered Drug, and after application of any Plan cost-share requirements, CHLIC shall charge the Employer the lowest of: (1) Gross Drug Cost (whether calculated as a discount off of the Covered Drug's AWP or a MAC); and (2) U&C Charge, as applicable. • For a specific Claim for a Covered Drug, CHLIC shall charge the Member the lowest of: (1) Gross Drug Cost (whether calculated as a discount off of the Covered Drug's AWP or a MAC): (2) U&C Charge, as applicable; and (3) The applicable flat dollar Plan copayment for the Covered Drug, if any. • Unless specifically noted herein, the discounts to Employer for Covered Drugs set forth in this Agreement are not guaranteed to result in an average aggregate discount off the aggregate AWP of all such Covered Drugs. • CHLIC may, upon written notice to Employer, adjust any or all of the fees, Rebates (if any), discounts or guarantees (if any) in this Agreement to the extent reasonably necessary to preserve the economic value of this Agreement as it existed immediately prior to any of the following events or changes: (a) there are any significant changes in the composition of the CHLIC pharmacy network utilized by Employer hereunder or in such pharmacy network's contract compensation rates, or the structure of the pharmacy stores/chains/vendors that are contracted with CHLIC, including but not limited to disruption in the retail pharmacy delivery model, or bankruptcy of a chain pharmacy; or (b) there is a change in government laws or regulations which has a significant impact on pharmacy claim costs; or (c) any material manufacturer-rebate contracts with, or for the benefit of, CHLIC are terminated or modified in whole or in part; or (d) there is any legal action or law that materially affects or could materially affect the manner in which CHLIC's rebate program is administered or an existing law is interpreted so as to materially affect or potentially have a material effect on CHLIC's administration of the Plan; (e) a major change in market conditions affecting the pharmaceutical or pharmacy benefit management market, a drug shortage in the market, an issue involving the safety of the drug supply, or similar market event occurs; or (f) there is a material change in the Plan that is initiated by Employer (and which CHLIC agrees to administer) which impacts CHLIC's costs, or Employer fails to disclose a material feature of the Plan or the Plan's Pharmacy Benefit.

DRUG MANUFACTURER-PAYMENT SHARING
Subject to the caveats below, CHLIC will remit to Employer the following portion of Rebates that CHLIC collects with respect to utilization of Covered Drugs under the Plan's Pharmacy Benefit: $40.00 per Retail Pharmacy Brand Drug Claim dispensed in a 30-day* supply, $101.00 multiplied by the number of Retail Pharmacy Brand Drug Claim dispensed in a 90-day** supply and $220.00 per Cigna Home Delivery Pharmacy Brand Drug Claim.
Caveats: (1) Upon termination of this Agreement, CHLIC may use Rebates otherwise payable to Employer to offset payable Bank Account Payments or other payable fees or changes identified in this Agreement. (2) Should Employer terminate this Agreement before completion of the then-current Plan Year, no Rebates shall be due with respect to that Plan Year as payments of Rebates is conditioned on CHLIC exclusively administering the Pharmacy Benefits for the entire Plan Year. (3) For percentage-based sharing arrangements, payout amount may differ slightly from the stated percentage when payout occurs before manufacturers' final reconciliations and payments are made to CHLIC. (4) Rebates are not paid out on Run-Out Claims, on Claims for pharmaceutical products covered under the federal 340B drug pricing program, on pharmaceutical products or supplies covered under the Plan's medical benefit or Compound Drugs. (5) CHLIC or its agent contracts with drug manufacturers on CHLIC's own behalf, and not as agent of the Employer or the Plan. (6) The Rebate minimum guarantees, if any, set forth in this Schedule of Financial Charges are, among any other conditions communicated in this Agreement or otherwise in writing to Employer, contingent on Employer's Pharmacy Benefit applying a 90-day supply limit for specialty drugs. In the event that Employer has adopted, or adopts, a 30-day supply limit for specialty drugs, CHLIC shall revise the stated Rebate minimum guarantees, if any, to the extent necessary to reflect CHLIC's revised estimate of Rebates it may collect on specialty drugs utilized under the Pharmacy Benefit. Timing of Rebate Pay-Out: Remittance will be provided within ninety (90) days after the close of each applicable calendar year for the portion of such calendar year that coincides with the Plan Year.

CIGNA HOME DELIVERY PHARMACY DISCLOSURE		
	Product	**Charge**
Cigna Home Delivery Pharmacy (a CHLIC affiliated company)	Specialty Drugs dispensed by Cigna Home Delivery Pharmacy and administered under the Plan's medical benefit. Cigna Home Delivery Pharmacy and any other licensed pharmacy affiliate of CHLIC may maintain product purchase discount arrangements and/or fee-for-service arrangements with pharmaceutical manufacturers and wholesale distributors. Cigna Home Delivery Pharmacy or any other licensed pharmacy affiliate of CHLIC contract for these arrangements on its own account in support of its pharmacy operations. These arrangements relate to services provided outside of this Agreement and other pharmacy benefit management arrangements and may be entered into without regard to whether a specific drug is on one of the formularies that CHLIC offers to entities like Employer that sponsor group health plans. Discounts and fee-for-service payments received by Cigna Home Delivery Pharmacy or any other licensed pharmacy affiliate of CHLIC are not part of the administrative fees or other charges paid to CHLIC in connection with CHLIC's services hereunder. This provision shall survive termination or expiration of the Agreement.	**The drug's charge under a national specialty drug discount schedule that generates a 12.5% annual average aggregate discount off AWP across specialty drug claims dispensed at Cigna Home Delivery Pharmacy to CHLIC's self-funded and insured group-client book of business.**
FEES FOR PROCESSING RUN-OUT CLAIMS		
OAP, HRA OAP, DPPO	Run-Out Period of twelve (12) months	**No Additional Cost**
Pharmacy Product	Run-Out Period of three (3) months for all pharmacy claims	**No Additional Cost**

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

CHLIC MEDICAL COST CONTAINMENT FEES

CHLIC administers the following programs to contain costs with respect to charges for health care service/supplies that are covered by the Plan. In administering these programs, CHLIC contracts with vendors to perform program related services. Specific vendor fees are available upon request subject to a mutually agreed upon non-disclosure agreement. CHLIC's charge for administering these programs is the percentage (indicated below) of either (1) the "net savings" (i.e. the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings, less the applicable vendor fee which generally ranges from 7-11% of the program savings) or (2) the "gross savings" (i.e. the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings; CHLIC pays the applicable vendor fee) or (3) the "recovery" (i.e. the amount recovered) as applicable.

For charges for covered services received from a non-Participating Provider (including emergency/urgent care services that are covered at the in-network benefit level), CHLIC may apply discounts available under agreements with third parties or through negotiation of the billed charges. These programs are identified below as the Network Savings Program Supplemental Network, and Medical Bill Review (pre-payment). CHLIC charges the percentage shown for administering these programs. Applying these discounts may result in higher payments than if the maximum reimbursable charge is applied. Whereas application of the maximum reimbursable charge may result in the patient being balance billed for the entire unreimbursed amount, applying these discounts avoids balance billing and substantially reduces the patient's out-of pocket cost.

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

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

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

a. the amount of provider's billed charge not exceeding the greater of a CHLIC determined percentage of the Medicare allowable amount (the 80th percentile of the reasonable and customary charge if there is no Medicare allowable charge) or the amount required by state or federal, law (in the case of emergency room services) for charges subject to CHLIC's benefit enhancement policy (patient may be balance billed by the provider if the provider's charge exceeds such amount), or

b. the provider's billed charge.

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

1.	Network Savings Program	**29% of net savings**
2.	Supplemental Network	**29% of net savings**
3.	Medical Bill Review – (Pre-payment Cost Containment for Non-contracted claims):	
	Inpatient Hospital Bill Review	
	• Line Item Analysis	**Lesser of 5% of hospital bill or the savings achieved**

	• Professional Fee Negotiation	**29% of net savings**
	Outpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
	Physician/Professional Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
4.	Medical Bill Review – (Pre or Post-payment Cost Containment for Non-contracted and Contracted claims):	
	• Bill Audit	**29% of the savings/recovery achieved plus hospital fees or expenses passed through**
	Diagnosis Related Grouping (DRG) Validation/Audits and Recovery. An overpayment audit and recovery program in which CHLIC or its vendors review paid claim data to identify overpayments based on inaccurate DRG coding.	**29% of recovery plus any fees or expenses passed through by the hospital or regulatory agency**
	Medical Implant Device Audits	**29% of recovery**
5.	COB Vendor Recoveries [Exclusive of pharmacy programs where claims are adjudicated at time prescription is received.]	**29% of recovery**
6.	Secondary Vendor Recovery Program	**29% of recovery**
7.	Provider Credit Balance Recovery Program	**29% of recovery**
8.	High Cost Specialty Pharmaceutical Audits (this service is only provided with respect to Medical coverage)	**29% of recovery**
9.	Class Action Recoveries	**35% of recovery**
10.	Eligibility Overpayment Recovery Vendor Services. Identification and recovery of funds in situations where the overpayment is due to the late receipt of Member termination information. (This service is only provided with respect to Medical coverage).	**29% of recovery**

CHLIC PHARMACY COST CONTAINMENT FEES		
CHLIC administers the following programs to contain costs with respect to charges for health care service/supplies that are covered by the Plan. In administering these programs, CHLIC contracts with vendors to perform program related services. CHLIC's charge for administering these programs is the percentage (indicated below) of the "recovery" (i.e. the amount recovered) as applicable.		
1.	Pharmacy Vendor Recoveries. CHLIC performs periodic audits of contracted pharmacies in order to determine the accuracy of payments to the pharmacy(ies). CHLIC's recovery vendor collects and remits to CHLIC all overpayments to pharmacy(ies), and CHLIC remits to Employer's Bank Account the balance collected from the recovery vendor, less the recovery fee set forth herein.	**30% of recovery**
2.	Class Action Recoveries. CHLIC identifies, monitors and participates, on behalf of Employer, in class action recoveries in connection with suits against pharmaceutical manufacturers whereby recoveries are apportioned to class members on a pro rata basis. CHLIC collects and retains as a recovery fee set forth herein of any recovery (net of attorneys' fees) attributable to Employer's Plan.	**35% of recovery**
CHLIC DENTAL COST CONTAINMENT FEES		
Dental Cost Containment	CHLIC administers the following program to contain costs with respect to charges for dental services that are covered by the Plan. Applies to 2nd tier of participating DPPO network providers and includes: • Access to an additional network of DPPO dentists who provide care at a discounted rate. Lower out-of-pocket expenses for Members and additional claim savings for Employer when receiving covered services from these DPPO dentists. • CHLIC retains the percentage identified herein of Employer and/or Member gross savings for access and to cover the 2nd tier network administrative cost. • CHLIC calculates the percentage identified herein as fees charged on a pay-as-you save basis. If there is no savings, there is no fee charged to Employer. Gross savings are calculated by taking what the dental professional would have charged if not participating in the network minus the dentist's contracted fee. The dental cost containment fee is charged to Employer via the appropriate Electronic Funds Transfer (EFT) cycle as a percent of the savings assessed weekly against the Bank Account and would appear on Bank Account activity report(s) as Vendor Fee Reimbursement.	**25% of gross savings**

CARE MANAGEMENT/COST CONTAINMENT PROGRAM FEES		
	CHLIC arranges for third parties to provide care management services to: (i) contain the cost of specified health care services/items overall with respect to all plans insured and/or administered by CHLIC, and/or (ii) improve adherence to evidence based guidelines designed to promote patient safety and efficient patient care.	**Specific vendor fees and care management program services are available upon request.**
EXTERNAL REVIEW AND CONSULTATIVE REVIEW FEES		
	When a Member elects an External Review (as that term is defined in ERISA) of a benefit determination by an independent third party, the cost of a specific third party review is dependent on the nature and complexity of the issue on appeal. In highly complex, non-routine cases or cases related to new technology or experimental-investigational treatment, as part of the internal appeal process a panel of external reviewers may be necessary. Third party review charges will be commensurate with the number of reviewers (usually only one is used), as well as their level of expertise and time required to complete the review.	**$500-$4,000 Review**
STRATEGIC ALLIANCES		
	CHLIC contracts directly or indirectly with other managed care entities and third party network vendors for access to their provider networks and discounts. These third parties charge either a network access fee, which is included in CHLIC's monthly charges, or a percentage of the savings realized on a claim by claim basis as a result of the application of their discounts. Charges based on percentage of savings may be paid from the Bank Account. Additional details regarding specific charges will be provided upon request.	**All Medical Products**
OTHER VENDORS AND HEALTH CARE SERVICES PROVIDERS		
	Fixed per person per period and fee-for-service charges for various vendors and other providers/arrangers of health care services and/or supplies will be paid as claims for Plan Benefits. In addition, performance-based payments to Participating Providers will be charged to the Bank Account. Such payments will be at the payment rates then in effect, which may be amended from time to time. Additional details regarding charges and the identity of the vendor or provider of health care services will be made available upon request.	**All Products**

NOTICE REGARDING PAYMENTS FROM THIRD PARTIES		
	Unless indicated otherwise in the Agreement or the Schedule of Financial Charges, CHLIC retains all Rebates or other amounts it may receive from manufacturers of pharmaceutical products covered under the Plan Pharmacy Benefit. Information on the aggregate amount of such Rebates or other amounts with respect to the Plan Pharmacy Benefit will be provided upon request. This provision shall survive termination or expiration of the Agreement.	**All Pharmacy Products**
	CHLIC may receive and retain payments under contracts with pharmaceutical manufacturers with respect to Members' utilization of the manufacturer's specialty drugs covered under the Employer's Plan medical benefit. If CHLIC enters into any such contracts, it does so on its own behalf, and not as agent of the Employer or the Plan. CHLIC contracts with pharmaceutical manufacturers for any such remuneration on its own behalf and for its own benefit, and not on behalf of Employer or the Plan. Accordingly, CHLIC retains all right, title and interest to any and all such remuneration received from manufacturer; neither Employer, its Members, nor Employer's Plan retains any beneficial or proprietary interest in any such remuneration, which shall be considered part of the general assets of CHLIC. This provision shall survive termination or expiration of the Agreement.	**All Medical Products**
	From time to time, CHLIC, directly or through its affiliates, arranges with third parties (e.g., service vendors, provider network managers) to provide various services (e.g., cost-containment services or health care services) in connection with the Plan. CHLIC and its affiliates may receive payments from such third parties to help defray CHLIC's expenses associated with its implementation and/or ongoing administration of these arrangements or as a reimbursement for services provided to such parties by CHLIC. CHLIC may also receive compensation from third-party vendors that Employer may retain based upon a referral from CHLIC or that Members may utilize following an introduction facilitated by CHLIC or an affiliate.	**All Products**

	COMPLIANCE ASSISTANCE	
	CHLIC shall provide the following services to assist Employer in meeting its compliance obligations under section 2715 of the Public Health Service Act as added by the Patient Protection and Affordable Care Act and applicable regulations with respect to the provision of the Summary of Benefits and Coverage ("**SBC**"), translation notice and glossary. Applicable to all medical plans including HRA and FSA which are considered "group health plans" subject to the SBC requirements.	
1.	Preparation of SBC, translation notice. CHLIC will not be responsible for any changes that Employer makes to the SBC.	**No charge**
2.	Provide SBC, translation notices prepared by CHLIC to Employer electronically as well as any updates or material modifications.	**No charge**
3.	Include in SBC a summary of benefits administered by carve-out vendor if Employer or carve-out vendor provides CHLIC with necessary carve-out benefit information at least twelve (12) weeks prior to the date the SBCs are to be delivered to Employer.	**$500 for each benefit option under the Plan for which carve-out vendor benefits are included in SBC**

ADDITIONAL SERVICES		
Service	**Description**	**Charge**
Clinical Program	**Cigna TheraCare® Program** – a targeted condition drug therapy management program that supports individuals using specialty medications for certain chronic conditions and helps them better understand their condition, medication side effects and importance of adherence.	**Included at No Additional Cost**
Pharmacy Utilization Management Program	**Essential Package** – a utilization management program under which some pharmaceutical products are subject to one or several coverage limitations, including prior authorization, step therapy and/or quantity limits. Under a prior authorization requirement, the requested drug is generally reviewed for clinical appropriateness based on the intended use in therapy. Under a step therapy requirement, the customer generally must try one or more preferred products, or demonstrate why trying the preferred product(s) would be clinically inappropriate, in order to obtain coverage for the requested drug.	**Included in Pharmacy Administration Fee**

Your Health First	A proactive health education and improvement program for Members with a chronic condition. The program involves services that span across the Member's health needs. Behavioral coaching principles and evidence based medicine guidelines are utilized to optimize self-management skills and foster sustained health improvements. The program targets a chronic population at high risk for near term and future high cost medical expenses. Members are identified as having a chronic condition through a variety of sources which may include: claims data, referrals, and self-identification. A variety of resources is provided to those with a chronic condition, including access to online tools, personalized support, and targeted materials. The program includes the following components for those with a chronic condition: • Chronic condition-specific coaching • Pre- and post-discharge calls • Lifestyle management coaching: stress, weight management and tobacco cessation • Treatment decision support and coaching In order to continuously assess the effectiveness of the program and/or test new ideas to further engage Members around their health, a small sample of Members may be placed in a comparison group which for a defined period of time receives alternative services or is suppressed from receiving proactive outreach, such as engagement letters and/or calls. This could affect a few Members targeted for outreach during this limited time period.	**For OAP and HRA OAP Products: Included in Medical Access Fee**
Claim Litigation	Claim Litigation Services	**$3,500.00 Flat Annual Amount Included in Medical Administration Charge**
Claim and Appeals	CHLIC will administer an optional second level of claim appeals	**$0.94/employee/year Included in Medical Administration Charge**
Internet-Based Enrollment and Eligibility Management System	CHLIC, either directly or through its affiliate, Cigna Benefit Technology Solutions, Inc., will grant to Employer and Participants a nontransferable limited license to access Cigna Guided Solutions, CHLIC's Internet-Based Enrollment and Eligibility Management System for online enrollment and selection of benefits. Products and services are outlined in the Employer Agreement provided to the Employer by Cigna. More specific information about the products, services, charges, grant of license and applicable restrictions are available upon request.	**Any fees payable will be in accordance with the separate Employer Agreement.**

One Guide	One Guide is an enhanced level of personalized benefit service which offers Members proactive, personalized guidance and a simplified Member experience. The One Guide solution combines human interaction- through One Guide agents- with a robust digital tool - through the myCigna native mobile app - so Members have quick, convenient access to personal benefit information, and can engage the way they prefer. The system simplifies and strengthens the connection between Members, their benefit plan, and their overall health and well-being. One Guide proactively engages Members with clear ways to save money, stay healthy, and improve health outcomes that lead to a healthy lifestyle. One Guide offers: • education on health plan features, account balances and ways to maximize benefits and earn available incentives • guidance in finding the right doctor, lab, convenience care or pharmacy • 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.	**$3.50/employee/month Included in Medical Access Fee**
Health Improvement Fund		
Health Improvement Fund	For clinical/wellness/behavioral programs offered by CHLIC that are purchased, CHLIC will establish a Health Improvement Fund in the amount of $100,000.00. This fund will be used to defray the cost of CHLIC designated and arranged health and wellness improvement programs (e.g. biometric screenings, flu shots) for employees of Employer and to reward participation in these programs. The Health Improvement Fund is a one-time credit to be used from 07/01/2018 – 06/30/2019. Unused funds cannot be rolled over and CHLIC must pre-approve use of the Health Improvement Fund. The Health Improvement Fund shall be extinguished upon termination of this Agreement and any fund amount not used prior to termination of this Agreement shall only be available to Employer for the purpose of funding the cost of those reimbursable services provided prior to such termination.	

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

EFFECTIVE JUNE 1, 2016

(Applicable to all Open Access Plus Products)

Department	CPT Code	Description	OAP Rate
All Departments	99213	OFFICE VISIT,EST EXP PROB FOC	$65.80
Adult Medicine	99396	WELL EXAM, EST, 40-64 YEARS	$102.94
Pediatrics	99392	WELL EXAM, EST, 1-4 YEARS	$85.77
Ophthalmology	66984	REMOVE CATARACT, INSERT LEN-Professional Fee only, at a facility	$700.01
Podiatry	11721	DEBRIDEMENT NAIL SIX OR MORE	$39.95
Radiology	71020	CHEST X-RAY, PA & LAT	$30.38
Radiology	G0202 + 77052	SCREENING MAMMOGRAPHY DIGITAL	$141.02
General Surgery	47562	LAPAROSCOPY;CHOLECYSTECTOMY-Professional Fee only, at a facility	$837.79
Optometry	92014	EYE EXAM & TREATMENT	$109.35
Lab	80053	COMPREHENSIVE METABOLIC PANEL	$14.87
Lab	80061	LIPID PANEL	$18.85
ASC (Ambulatory surgical center) / Endoscopy Suite	Grouper 2		$469.00
ASC (Ambulatory surgical center) / Endoscopy Suite	Grouper 8		$1,104.00

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

The Urgent Care case rate excluding radiology and laboratory services is $115.

CMG pharmacy rates (30-day supply):

Brand Name: AWP – 10.56% + $2.75 dispensing fee

Generic: AWP – 35% + $2.75 dispensing fee

Appendix A – Pharmacy Benefit Management Services

PHARMACY BENEFIT MANAGEMENT - DEFINITIONS
Definitions Any capitalized term not defined below shall have the meaning given to such term in the Agreement. Any capitalized term utilized in the Schedule of Financial Charges or Exhibit B shall have the meaning given to such term in the Agreement, including the meanings set forth below. • "Actuarially Estimated" shall mean that the discount(s) listed in the Schedule of Financial Charges are estimated, but not guaranteed, to result in a particular discount for Covered Drugs. Actuarially estimated discounts are calculated based on evaluation of an expected distribution of drug utilization across CHLIC's aggregate group client book of business. As measured in the aggregate for Employer's Pharmacy Benefit, Employer's results may vary based on the Plan-specific factors such as drug mix utilization. • "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"), Covered Drug specific, quantity appropriate actual package size (or the manufacturer-packaged quantity closest to the dispensed size), submitted by a Retail Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy at the time that the Covered Drug is adjudicated. In the event a repackaged or relabeled NDC is dispensed, the lowest cost AWP for the equivalent drug dosage form, strength, Brand Drug / Generic Drug designation, and formulation and package size from a non-repackager or non-relabeler shall be applied. 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, including, for example, any change in the markup, methodologies, processes or algorithms underlying the published AWP(s), CHLIC may adjust any or all of the Rebates, charges, rates, discounts, guarantees and/or fees in connection with CHLIC's administration of the Pharmacy Benefit hereunder, including any that are based on AWP, as it reasonably deems necessary to preserve the economic value or benefit of this Agreement to the Parties as it existed immediately prior to such change. Additionally, and notwithstanding any other provision in this Agreement, CHLIC may replace AWP as its pharmaceutical pricing benchmark with an alternative benchmark and/or may replace Medi-Span, or other such publication, as its source for the AWP or alternative benchmark with a different pricing source, provided that CHLIC adjusts any or all such AWP-based charges or such alternative benchmark-based charges as it reasonably deems necessary to preserve the economic value or benefit of this Agreement to the Parties as it existed immediately prior to such replacement or immediately prior to the event(s) giving rise to such replacement, as the case may be. • "Brand Drug" shall mean a pharmaceutical product, including a Covered Drug that is a prescription drug, including over-the-counter drugs dispensed pursuant to a prescription, medicine, agent, substance, device, supply or other therapeutic product that is not a Generic Drug. • "Business Decision Team" shall mean a committee comprised of voting and non-voting representatives across various Cigna business units such as clinical, medical and business leadership that is duly authorized by Cigna to make decisions regarding coverage treatment of pharmaceutical products based on clinical findings provided by the P&T Committee, including, but not limited to, decisions regarding tier placement and application of utilization management to pharmaceutical products.

- "Cigna Home Delivery Pharmacy" shall mean a duly licensed pharmacy operated by CHLIC or its affiliates, where prescriptions are filled and delivered via the mail service, which may include Tel-Drug, LLC of Pennsylvania and Tel-Drug, Inc. of South Dakota.
- "Claim", for purposes of this Appendix A, is a claim or request for coverage under the Pharmacy Benefit.
- "Compound Drug" shall mean a medication that (a) is comprised of two or more gaseous, solid, semi-solid, or liquid ingredients (other than water or flavoring added to any preparation) that are weighed or measured at a pharmacy and then prepared according to the prescriber's order and the pharmacist's art; (b) contains at least one FDA-approved federal legend drug as an active ingredient; (c) is not otherwise generally available in its compound form; and (d) is not a compound preparation administered by infusion or injection.
- "Covered Drugs" shall mean prescription drugs, including over-the-counter drugs dispensed pursuant to a prescription, biologics, medicines, agents, substances, devices, supplies, and other therapeutic products that are prescribed for Members and are covered under the Pharmacy Benefit and shall include all associated standard services usually and customarily rendered by a pharmacy or provider in the normal course of business, including dispensing, administration, counseling and product consultation.
- "Dispensing Fee" means an amount paid to a pharmacy for providing professional services necessary to dispense a Covered Drug to a Member.
- "FDA" shall mean the U.S. Food and Drug Administration.
- "Formulary" shall mean the list of FDA-approved prescription drugs and supplies developed and managed by CHLIC across its self-funded and insured group book of business and that is selected and adopted by Employer. The drugs and supplies included on the Formulary will be modified by CHLIC from time to time as a result of factors including, but not limited to, economic and clinical factors like clinical appropriateness, manufacturer Rebate arrangements and patent expirations. Any changes CHLIC makes to the Formulary are hereby adopted by Employer.
- "Generic Drug" means a pharmaceutical product, including a Covered Drug, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the FDA as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient(s), and which is identified as such in CHLIC's master drug file using indicators from First Databank, Medi-Span, or other nationally recognized source as used by CHLIC across its book of business on the basis of a proprietary algorithm, a summary of which may be made available for review by Employer or, subject to CHLIC's consent, its auditor upon request in accordance with the terms set forth in this Appendix A. Employer and, as applicable, its auditor shall sign a confidentiality agreement acceptable to CHLIC relating specifically to such summary. The reference to a drug by its chemical name does not necessarily mean that the product is recognized as a generic for adjudication, pricing or copay purposes. For pricing purposes, a Generic Drug excludes a Covered Drug that is either marketed under three (3) or fewer Abbreviated New Drug Application pursuant to 21 USC §355, and its implementing regulations, or cannot be purchased by the pharmaceutical industry at large from more than one pharmaceutical wholesaler.
- "Gross Drug Cost" shall mean the sum of the total discounted cost to Employer and/or a Member for a Covered Drug plus any applicable Dispensing Fee, plus and sales tax or other tax applied thereto.
- "Maximum Allowable Charge" shall mean the maximum unit price for a Covered Drug included on the applicable MAC List as set forth on such MAC List.

- "MAC List" shall mean a then-current list maintained by CHLIC of prescription drugs, devices, supplies and over-the-counter drugs identified as readily available as a Generic Drug or generally equivalent to a Brand Drug (in which case it may also be on a MAC List) and that, in each case, are deemed to require or are otherwise capable of pricing management due to the number of manufacturers, utilization and/or pricing volatility.

- "Pharmacy Benefits" shall mean amounts payable for covered pharmacy benefit services and products under the terms of the Plan; Pharmacy Benefits shall be considered Plan Benefits for purposes of this Agreement.

- "P&T Committee" shall mean a committee comprised of both voting and non-voting Cigna-employed clinicians, Medical Directors and Pharmacy Directors and non-employees such as Participating Providers that represent a range of clinical specialties. The committee regularly reviews pharmaceutical products, new pharmaceutical products, for safety and efficacy, the findings of which clinical reviews inform coverage status decisions made by the Business Decision Team. The P&T Committee's review may be based on consideration of, without limitation, FDA-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

- "PBM Proprietary Information" shall mean information relating to CHLIC's pharmacy benefit management products and services, including, without limitation, CHLIC's reporting and web-based applications, eligibility and adjudication systems and coding methodologies, system formats and databanks, clinical or formulary management operations or programs, information and agreements relating to Rebates and other financial information, prescription drug evaluation criteria and coverage policies, drug pricing information, including MAC List and Specialty Drug pricing, paid Claims information integrated into CHLIC's adjudication systems, and pharmaceutical manufacturer, vendor or pharmacy network agreements.

- "Rebate" shall mean the following payments or other consideration paid or payable to CHLIC from manufacturers to the extent arising from or as a result of Covered Drugs dispensed to Members and/or the performance of any pharmacy benefit management services provided under the Agreement.

(a) Payments, rebates and other consideration paid to CHLIC from any manufacturer arising from or as a result of the inclusion or exclusion on any Formulary of Covered Drugs manufactured, sold, marketed, or distributed by any manufacturer;

(b) Rebates, discounts, service fees and other consideration paid to CHLIC from any manufacturer arising from or as a result of any arrangements, commitments, programs or activities involving or relating to utilization (e.g., market share, growth, etc.) of certain prescription drugs within their respective therapeutic categories; and

(c) Rebates, discounts, service fees and other consideration paid to CHLIC from any manufacturer arising from or as a result of any arrangements, commitments, programs or activities involving or relating to services performed by CHLIC where CHLIC is paid or is entitled to fees or other compensation on the basis of the volume or value of prescription drugs or other products that are prescribed or dispensed to CHLIC customers.

However, "Rebates" shall exclude: (i) pricing adjustments, payments and credits made in the ordinary course by any manufacturer on account of product returns, delivery errors or shipping damage or losses arising from drugs and other products purchased from such manufacturer by or on behalf of CHLIC; (ii) pricing discounts paid or credited by a manufacturer to pharmacies affiliated with CHLIC for prescription drugs and other products purchased from such manufacturer; (iii) any fees or other compensation paid by any manufacturer in consideration of any services, products, activities or programs performed, provided or implemented by CHLIC or any of its affiliates for such manufacturer; (iv) payments, rebates or other compensation paid to CHLIC for or by reason of any administrative or other services provided by CHLIC to or for any manufacturer, in connection with administering, computing, invoicing,

allocating and/or collecting amounts otherwise constituting Rebates; and (v) rebates or other amounts paid to CHLIC for prescription drugs that are administered or otherwise provided to Members in providers' offices or outpatient clinics.

- "Retail Pharmacy" shall mean any licensed retail pharmacy with which CHLIC has contracted directly or indirectly with a third party, to provide Covered Drugs to Members, and is not a mail order pharmacy. A mail order pharmacy is a pharmacy that primarily fills and delivers pharmaceutical products via the mail service. The term "Retail", when immediately preceding the term "Brand Drug Claim," "Generic Drug Claim," "Specialty Drug Claim," "Specialty Brand Drug Claim, or "Specialty Generic Drug Claim" means that the resulting term (e.g., "Retail Brand Drug Claim") refers to such claim as dispensed by a Retail Pharmacy.

- "Specialty Drug" shall mean a pharmaceutical product, including a Covered Drug, considered by CHLIC to be a Specialty Drug based on consideration of the following factors: (i) whether the pharmaceutical product is prescribed and used for the treatment of a complex, chronic or rare condition; (ii) whether the pharmaceutical product has a high acquisition cost; and, (iii) whether the pharmaceutical product is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Drug may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a pharmaceutical product will be considered a Specialty Drug. The term "Specialty," when immediately preceding the terms "Generic Drug" or "Brand Drug", means that the resulting term (e.g. "Specialty Generic Drug") refers to a Generic Drug or Brand Drug that is considered a Specialty Drug, respectively.

- "Specialty Pharmacy" shall mean a duly licensed pharmacy designated by or operated by CHLIC or its affiliates that primarily dispenses Specialty Drugs or provides services related thereto; provided, however, that when the Cigna Home Delivery Pharmacy dispenses a Specialty Drug, it shall be considered a Specialty Pharmacy hereunder.

- "U&C Charge" shall mean the price the applicable Retail Pharmacy would charge a regular cash-paying customer for a Covered Drug (and any services related to the dispensing thereof) on the day on which the Covered Drug is dispensed, exclusive of applicable taxes.

PHARMACY BENEFIT MANAGEMENT – SERVICES TO BE PROVIDED

1. Retail Pharmacy Network.

(a) General. CHLIC shall maintain a Retail Pharmacy network. Retail Pharmacies included in the network shall provide Covered Drugs to which the Retail Pharmacies have access to Members during their normal business hours in all applicable locations. A list of the Retail Pharmacies included in the network, as updated from time to time, shall be made available to Members online. CHLIC maintains multiple networks and/or sub-networks and may periodically consolidate networks and/or migrate clients, including Employer, between networks and sub-networks. CHLIC shall require each Retail Pharmacy included in the network to meet its requirements for participation in the Retail Pharmacy network, which include, but are not limited to, satisfaction of licensing and insurance requirements.

(b) Retail Pharmacy Audits and Overpayments. CHLIC shall perform desktop and on-site audits of each Retail Pharmacy to ensure that each Retail Pharmacy is complying with the terms of its contract with CHLIC. In the event that CHLIC discovers that an overpayment has been made to a Retail Pharmacy, CHLIC shall take reasonable steps to recover the overpayment pursuant to the terms of this Agreement.

(c) Independent Contractors. The Retail Pharmacies are independent contractors, and CHLIC does not exert direction or control over the pharmacists at Retail Pharmacies in filling prescriptions or performing other pharmaceutical services.

(d) Collection of Cost Sharing. CHLIC shall require Retail Pharmacies to collect all applicable Plan cost-shares from Members.

2. **Cigna Home Delivery Pharmacy.**

(a) General. Members may submit new or refill prescription orders for fulfillment through Cigna Home Delivery Pharmacy or such other mail service pharmacy that CHLIC in its sole discretion may select from time to time. Such orders may be placed via mail, telephone, or electronic means. Subject to Applicable Law, Employer shall permit CHLIC to communicate with Members regarding availability and use of the Cigna Home Delivery Pharmacy and potential cost savings associated therewith. In addition, CHLIC may provide supporting services with respect to the Cigna Home Delivery Pharmacy. Cigna Home Delivery Pharmacy shall deliver all drugs to Members in accordance with its standard procedures. For the purposes of clarity, CHLIC does not exert direction or control over the pharmacists at Cigna Home Delivery Pharmacy in filling prescriptions or performing other pharmaceutical services.

(b) Cost Sharing. Members are responsible for payment of the applicable cost sharing to Cigna Home Delivery Pharmacy for each prescription or prescription refill. Employer acknowledges that Cigna Home Delivery Pharmacy may suspend services to a Member who is in default of any cost-sharing obligations, in accordance with Cigna Home Delivery Pharmacy's standard credit policy. If payment of such cost-sharing has not been received from the Member within one hundred twenty (120) days of dispensing of the product, the Plan will be billed for the outstanding amount following the one hundred twenty (120) day collection period.

(c) Affiliation with CHLIC. Tel-Drug of Pennsylvania, LLC and Tel-Drug, Inc. of South Dakota are licensed pharmacy affiliates of CHLIC that fill and deliver Covered Drugs via the mail service.

3. **Claims Processing.**

(a) General. CHLIC shall perform claims processing services for Covered Drugs dispensed by Retail Pharmacies or Cigna Home Delivery Pharmacy. In-network Claims shall be submitted via paper or electronically. Members using out-of-network covered services are required to submit a paper claim form. A separate charge shall apply for submission of any paper claim form, whether in-network or out-of-network. CHLIC does not provide coordination of benefits (COB) services for Claims for drugs dispensed, and electronically processed, at a pharmacy; Claims will be processed without consideration of a Member's coverage under another plan.

(b) Drug Utilization Review. CHLIC shall perform a concurrent Drug Utilization Review ("DUR") analysis of each prescription submitted for processing, which may include: (1) prescribed dosage within a safe range; (2) drug-to-drug interaction; (3) drug-to-allergy interaction; (4) age-to-drug interaction; (5) duplicate therapy; (6) quantity limitations; and (7) days' supply. CHLIC's DUR processes shall not override or substitute for the prescriber's, the pharmacist's or other health care provider's professional judgment.

4. **Utilization Management Program.** CHLIC shall, in accordance with Section 2 of the Agreement, administer the Pharmacy Benefit utilization management program(s) identified in this Agreement. Employer acknowledges that CHLIC's coverage policies and claims administration procedures, which are utilized across CHLIC's self-funded and insured book-of-business to adjudicate claims and administer appeals, may change periodically. Employer further authorizes CHLIC to allow coverage for a use that would be otherwise excluded in the event of co-morbidities, complications and other

factors not expressly addressed by the coverage policies utilized by CHLIC in reviewing Claims for coverage. CHLIC may rely wholly upon information about the Member and the prescriber's diagnosis of the Member's condition. CHLIC shall not substitute its judgment for the judgment of the prescribing physician, nor shall it determine medical necessity or make other medical determinations other than for coverage purposes.

5. **Rebate Management.** CHLIC shall pay Employer amounts equal to the Rebate amounts specified on the Schedule of Financial Charges.

6. **Drug-Related Services.**

(a) Generic Drugs and Brand Drugs. CHLIC shall process Claims regarding Generic Drugs and Brand Drugs.

(b) Specialty Drugs. CHLIC shall process Claims regarding Specialty Drugs subject to the following provisions:

(1) The Specialty Pharmacy shall fill prescriptions for Specialty Drugs based on the professional judgment of the dispensing pharmacist, accepted pharmacy practices and product guidelines.

(2) A list of Specialty Drugs available via the Specialty Pharmacy and pricing with respect thereto shall be made available as in effect on the Effective Date, are set forth in Appendix B. After the Effective Date, Employer may request that CHLIC provide it with an updated list of Specialty Drugs available via the Specialty Pharmacy and pricing with respect thereto.

(3) To the extent acting in the capacity as a mail order pharmacy, the Specialty Pharmacy shall ship Specialty Drugs to Members in accordance with its standard procedures.

(4) Members are responsible for payment of the applicable cost sharing to the Specialty Pharmacy for each prescription or prescription refill. Employer acknowledges that the Specialty Pharmacy may suspend services to a Member who is in default of any cost-sharing obligations, in accordance with the Specialty Pharmacy's standard credit policy. If payment has not been received from the Member within one hundred twenty (120) days of dispensing, the Plan will be billed following the one hundred twenty (120) day collection period.

(5) For the purposes of clarity, CHLIC does not exert direction or control over the pharmacists at the Specialty Pharmacy in filling prescriptions or performing other pharmaceutical services.

(c) Compound Drugs. CHLIC shall process prescribed Compound Drugs to the extent covered under the Plan. CHLIC shall treat as Covered Drugs only those components of a Compound Drug that would otherwise be treated as Covered Drugs were they not part of a Compound Drug.

7. **Member Communications and Services.**

(a) Member Communication. CHLIC shall provide to Members an ID card and instructions to access Member materials online, including the Formulary, the Retail Pharmacy directory, Cigna Home Delivery Pharmacy information, and an out-of-network Claim reimbursement form.

(b) Rx Savings Messenger. CHLIC may send personalized mailings to Members regarding the Generic Drugs and preferred Brand Drugs and savings available from Cigna Home Delivery Pharmacy.

(c) Call Center. CHLIC shall maintain toll-free customer service lines twenty-four (24) hours per day, seven (7) days per week for the purpose of responding to inquiries from Members regarding Retail Pharmacy, Cigna Home Delivery Pharmacy or Claims issues.

8. Formulary Management; Clinical Programs; Other Services.
CHLIC shall provide Formulary management services, which shall include implementing Formulary placement decisions and determinations to apply utilization management requirements made by CHLIC's Business Decision Team. The Business Decision Team makes Formulary determinations based on consideration of clinical and economic factors. Clinical factors may include, but are not limited to, the CHLIC P&T Committee's evaluation of the place in therapy, relative safety or relative efficacy of the drug, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the drug's acquisition cost including, but not limited to, assessments on the cost effectiveness of the drug and available Rebates. When considering a drug for Formulary placement or other coverage conditions, CHLIC's Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its book-of-business. CHLIC shall also provide the clinical, safety and/or trend programs, or other programs and services selected by Employer as indicated on the Schedule of Financial Charges or otherwise agreed upon by Employer and CHLIC, some of which may require payment of additional fees. If Employer changes its Formulary selection, changes Plan benefit designs, implements over-the-counter plans, implements clinical or trend programs, or otherwise takes an action that has the effect of lowering the amount of Rebates earned hereunder or materially impacting any guarantee, then CHLIC shall have the right, upon notice, to make an equitable adjustment to the rates, fees, and/or Rebates under this Agreement, solely as necessary to return CHLIC to its contracted economic position as of the effective date of such event.

PHARMACY BENEFIT MANAGEMENT – PROGRAM OPERATIONS

1. Implementation of Agreement.

(a) Project Plan. Employer and CHLIC shall develop an agreed upon implementation project plan with respect to the Agreement prior to the Effective Date or prior to the implementation with respect to any new Pharmacy Benefit under this Agreement following the Effective Date.

(b) Initial Data and Commencement of Pharmacy Benefit Management Services. Prior to the Effective Date, Employer shall provide CHLIC with all data and/or documentation necessary for CHLIC to provide the services specified in this Agreement. Such data and/or documentation shall include, but is not necessarily limited to, claims history and Member prior authorization history. Assuming all data specified in the preceding sentence is received sufficiently in advance of the Effective Date, CHLIC shall commence providing services under this Agreement as of the Effective Date.

2. Timely Provision of Data by Employer. Employer acknowledges that CHLIC shall not be held responsible for, and shall be released from, fulfilling any obligation or performing any service under this Agreement if Employer or its designee does not provide accurate information in a timely manner.

3. Reporting. CHLIC shall make available to Employer CHLIC's standard reporting applications, subject to Applicable Law and Exhibit D, including, without limitation, HIPAA and state privacy laws.

4. Claims Data.

(a) Retention. CHLIC shall retain data with respect to Claims for at least seven (7) years from the date the prescription is filled. Following the close of such retention period, CHLIC shall retain and dispose of such Claims data pursuant to its then-current standard policies and procedures, Applicable Law and

the business associate agreement described in the Agreement.

(b) Disclosure to Vendor. Upon Employer's written request and subject to execution of a non-disclosure agreement acceptable to CHLIC, CHLIC shall provide prescription Claims data in its standard format to a vendor contracted with Employer's vendor and otherwise acceptable to CHLIC solely for the purposes of such vendor's support of Plan administration functions. Employer agrees that its vendors may not utilize Claims data for any other purpose, including, without limitation, developing products and services, analyzing the Claims data against market benchmarks or CHLIC competitors or adding to a normative database (even if de-identified and/or blinded as to Member and PBM/carrier) for the Employer's or vendor's commercial use. Employer shall be responsible for any use or disclosure of Claims data, or any services provided, by the vendor. Notwithstanding the foregoing, all audits of any pricing guarantees, Rebate-sharing obligations or Claims processing accuracy shall be conducted in accordance with the terms in this Agreement specifically relating to such audits

(c) De-Identified Data. During and after the term of this Agreement, CHLIC may use Claims, drug, and medical data that has been de-identified in accordance with HIPAA for research, provider evaluation, database maintenance, and other commercial purposes.

This provision shall survive termination or expiration of the Agreement.

5. **Claims Processing Audits.** Employer may, in accordance with the requirements set forth in Section 6 of the Agreement and at no additional charge while this Agreement is in effect, audit CHLIC's payment of Plan Benefits subject to the conditions set forth in Section 6 of the Agreement.

6. **Rebate Audits.** Employer may, to the extent specified below, in accordance with the following requirements, and at no additional charge while this Agreement is in effect, audit CHLIC's Rebate payments subject to the following conditions:

(a) Employer shall designate with CHLIC's consent, such consent not to be unreasonably withheld, an independent, third party auditor to conduct the audit (the "Auditor").

(b) The Auditor may audit records directly related to CHLIC's performance of its obligations hereunder regarding Rebates once in each 12-month period upon the following conditions: (1) Employer shall provide at least 45 days written notice to CHLIC; (2) the Auditor (including each auditor conducting the audit) shall be agreeable to Employer and CHLIC; (3) a mutually agreed upon nondisclosure/nonuse contract shall be executed by Employer, the Auditor and CHLIC; (4) the records to be audited shall be no more than two years old as of the date of the audit; (5) the scope of records to be audited shall be as mutually agreed upon by the Auditor and CHLIC as those which are necessary to determine compliance with the Rebate-sharing obligations under this Agreement; (6) the audit shall be conducted at a mutually acceptable time during regular business hours at CHLIC's office where such records are located; (7) records shall not be removed or photocopied without CHLIC's express written consent; (8) the Auditor shall provide its audit report to CHLIC and Employer at the same time; and (9) the Auditor may disclose the aggregate amount of Rebates due Employer but no other details of CHLIC's manufacturer contracts of which the Auditor is apprised, if any.

This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT – FUNDING AND PAYMENT OF CLAIMS; CHARGES
1. **Funding and Payment of Claims.** With respect to Pharmacy Benefits, (1) CHLIC may withdraw funds from the Bank Account for the purposes specified in Section 3 of the Agreement five times per month, and (2) any recovered overpayments shall be credited to Employer via a line item on its invoice, less the fee set forth on the Schedule of Financial Charges. 2. **Retroactive Member Changes and Terminations**. Notwithstanding anything in the Agreement to the contrary, Employer shall remain responsible for all charges and Bank Account Payments incurred or charged through the date CHLIC processed Employer's notice of a retroactive change or termination of a Member's enrollment in the Plan. Notwithstanding anything to the contrary in Section 4.c. of the Agreement, with respect to Pharmacy Benefits, CHLIC generally will implement eligibility updates received from Employer that adhere to CHLIC's standard electronic format as soon as reasonably practicable following receipt of such updates.
PHARMACY BENEFIT MANAGEMENT – FIDUCIARY ACKNOWLEDGMENTS
CHLIC offers pharmacy benefit management services for consideration by Employer and other entities. The general parameters of such services and the supporting systems have been developed by CHLIC as part of CHLIC's administration of its general business as a pharmacy benefit manager for entities that sponsor group health plans. The Parties have negotiated the terms of this Agreement in an arm's-length fashion. The Parties assert that neither Party intends that CHLIC shall be a fiduciary with respect to Pharmacy Benefits for either ERISA (if applicable) or state law purposes, and neither Party shall name CHLIC as a "plan fiduciary" with respect to its management of Pharmacy Benefits. Employer acknowledges and agrees that CHLIC (i) does not have discretionary authority or control respecting management of the Pharmacy Benefits, and (ii) does not exercise any authority or control respecting management or disposition of the assets relating to Pharmacy Benefits or of Employer. Rather, Employer retains all such authority and control. The Parties agree that, upon reasonable notice, CHLIC shall have the right to terminate its Pharmacy Benefit services under this Agreement to any Plan and/or Members located in a state that requires a pharmacy benefit manager to be a fiduciary to Employer, the Plan or a Member. This provision shall survive termination or expiration of the Agreement.
PHARMACY BENEFIT MANAGEMENT – FINANCIAL ARRANGEMENTS
1. **General.** CHLIC contracts on its own account with Retail Pharmacies to dispense covered pharmaceutical products to Employer's Members, and not on behalf of, or for the benefit of, Employer or the Plan; accordingly, any discounts or other remuneration CHLIC earns under an arrangement with a Retail Pharmacy are obtained for, and inure to, the sole and exclusive benefit of CHLIC, and not the Employer of the Plan. Amounts paid to the Retail Pharmacy for Brand Drug, Generic Drug, or Specialty Drug Claims may or may not be equal to the amount charged to Employer and/or Member. If the amount paid by Employer and/or Member does not equal the amount paid by CHLIC to a particular pharmacy, CHLIC will absorb or retain such difference. CHLIC contracts with pharmaceutical manufacturers for Rebates and other remuneration on its own behalf and for its own benefit, and not on behalf of Employer or the Plan. Accordingly, CHLIC retains all right, title and interest to any and all actual Rebates and other remuneration received from manufacturers. CHLIC will pay Employer amounts equal to all or some portion of the Rebate amounts allocated to Employer, if any, and as specified on the Schedule of Financial Charges, from CHLIC's general assets (neither Employer, its Members, nor Employer's Plan retains any beneficial or proprietary interest in CHLIC's general assets). Rebate amounts received vary based on factors including, without limitation, Employer-specific utilization, the volume of utilization as well as Formulary position applicable to the drug or supplies, and adherence to various formulary management controls, benefit design requirements, Claims volume, and in certain instances also may vary based on the product market share. Employer acknowledges and agrees that neither it, its Members nor its Plan will have a

right to interest on, or the time value of, any Rebate payments received by CHLIC during the collection period or moneys payable under this section.

2. **Affiliates.** Cigna Home Delivery Pharmacy and any other licensed pharmacy affiliate of CHLIC may maintain product purchase discount arrangements and/or fee-for-service arrangements with pharmaceutical manufacturers and wholesale distributors in its capacity as a mail service and/or specialty pharmacy. Cigna Home Delivery Pharmacy or any other licensed pharmacy affiliate of CHLIC may contract for these arrangements on its own account in support of its pharmacy operations, and not on behalf of, or for the benefit of, Employer of the Plan. Accordingly, Cigna Home Delivery Pharmacy and any other licensed pharmacy affiliate of CHLIC retains the sole and exclusive benefit of any difference between its acquisition cost for a pharmaceutical product and the amount charged to Employer under this Agreement. Further these arrangements relate to services provided outside of this Agreement and other pharmacy benefit management arrangements and may be entered into without regard to whether a specific drug is on one of the formularies that CHLIC offers to entities that sponsor group health plans. Discounts and fee-for-service payments received by Cigna Home Delivery Pharmacy or any other licensed pharmacy affiliate of CHLIC are not part of the pharmacy benefit management formulary rebates or associated administrative fees or charges paid to CHLIC in connection with CHLIC's pharmacy benefit management formulary rebate programs.

This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT – OBLIGATIONS UPON TERMINATION

Upon notice of termination of this Agreement, the following provisions shall apply with respect to Pharmacy Benefits:

(a) Employer shall notify Members at least thirty (30) days prior to the termination of the Agreement becoming effective of any transition to a successor pharmacy benefit manager.

(b) If mutually agreed upon by CHLIC and Employer, CHLIC shall provide services following termination of the Agreement at CHLIC's then-prevailing rate. Such services, if any, shall be determined by mutual agreement of CHLIC and Employer in advance of the termination of the Agreement becoming effective.

(c) Upon request by Employer and subject to execution of a nondisclosure agreement acceptable to CHLIC, CHLIC shall transition Claims files and/or history to the pharmacy benefit manager or other third party specified by Employer and otherwise acceptable to CHLIC. Any disclosure of Claims files and/or history shall be limited to the information the successor pharmacy benefit manager or other third party needs to implement or administer Employer's pharmacy benefits. CHLIC shall not be required to directly or indirectly release, and Employer shall not release, PBM Proprietary Information to any such third party.

(d) Upon termination of the Agreement for any reason, the Parties shall handle Confidential Information, PBM Proprietary Information and Protected Health Information (as defined in the Business Associate Agreement attached as Exhibit D) pursuant to the terms of the Agreement.

This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT – REMEDIES
(a) **Remedies Not Exclusive.** A Party's right to terminate the Agreement shall not preclude use of any other remedies available to such Party under the Agreement or otherwise, at law, or in equity. (b) **Suspension of Performance.** In the event (i) Employer makes an assignment for the benefit of creditors; (ii) Employer is the subject of a voluntary or involuntary petition for bankruptcy or is adjudged insolvent or bankrupt; or (iii) a receiver or trustee is appointed for any portion of Employer's rights or property, CHLIC may immediately, and without penalty or any liability for any Employer losses, suspend performance of services hereunder. (c) **Financial Responsibility.** Without limiting CHLIC's right to terminate this Agreement, CHLIC reserves the right to require Employer to make a deposit as described in this subsection (c). If at any time during the term of this Agreement, Employer fails to comply with the payment terms established hereunder on three (3) or more occasions within a four (4) month period, then CHLIC may request information and/or reasonable assurances and/or a deposit from Employer as to Employer's financial responsibility. Any such deposit shall be in an amount equal to two (2) billing cycles based upon the average of the last three (3) months of billing history. Employer shall provide any such deposit within ten (10) calendar days following the request. CHLIC may apply any such deposit to past due balances and shall return any remaining deposit after the termination of this Agreement and the payment of all amounts payable to CHLIC hereunder. Any deposit provided by Employer shall be paid from the general assets of Employer and not from assets of the Plan and shall not be considered Plan assets. This provision shall survive termination or expiration of the Agreement.
PHARMACY BENEFIT MANAGEMENT – CONFIDENTIALITY
1. General. Employer acknowledges and agrees that CHLIC's PBM Proprietary Information constitutes competitively sensitive trade secrets, and that its misuse or mis-disclosure could result in material financial and legal loss or liability to CHLIC, its affiliates and their respective subcontractors. CHLIC shall not be required to disclose PBM Proprietary Information to Employer, or its vendor or designee, except to the extent necessary for Employer to exercise any audit rights expressly provided hereunder or perform other Plan administration functions. If CHLIC discloses PBM Proprietary Information to Employer, or, if CHLIC consents, to the Employer's vendor or designee, CHLIC may require Employer, or its vendor or designee, to execute a non-disclosure agreement specifically relating to the requested PBM Proprietary Information. Notwithstanding the foregoing, in no event will CHLIC be required to disclose information related to, or including, its pharmacy network agreements, vendor agreements or pharmaceutical manufacturer agreements. Employer agrees that it and its vendors may not utilize PBM Proprietary Information for any purpose other than performing Plan administration functions, including, without limitation, developing products and services, de-identifying, blinding or analyzing the PBM Proprietary Information against market benchmarks or CHLIC competitors or adding to a normative database for the Employer's, or vendor's or designee's, commercial use. For the purposes of clarity, information shall not cease to qualify as PBM Proprietary Information if Employer or its vendor or designee de-identifies and/or blinds the PBM Proprietary Information such that the information cannot be traced or identified to a Member or CHLIC, its affiliates or their respective subcontractors. Employer shall be solely responsible for any disclosure of PBM Proprietary Information by CHLIC to Employer or its vendor or designee, or any subsequent use or disclosure by Employer or its vendor or designee, or services provided by the same. Notwithstanding the foregoing, in no event will CHLIC be required to disclose to Employer, or its vendor or designee, information related to, or including, its pharmacy network agreements, vendor agreements or pharmaceutical manufacturer agreements.

2. Compelled Disclosures. If at any time Employer, or its vendor or designee, is required by law, court order or other valid legal process to disclose any Confidential Information, it will promptly notify CHLIC prior to any such compelled disclosure and, upon request, cooperate with CHLIC in seeking a protective order or other available relief to contest or limit the scope of such compelled disclosure.

3. Return or Destruction of Information. At any time upon CHLIC's request or upon expiration or termination of this Appendix A or the Agreement, whichever occurs first, Employer will, at CHLIC's option, promptly deliver, or, as the case may be, compel its vendor or designee to deliver, to CHLIC all PBM Proprietary Information or other Confidential Information (or such portion thereof as requested) and not retain any copies in whole or in part of such PBM Proprietary Information or other Confidential Information, or securely destroy or dispose, or, as the case may be, compel its vendor or designee to destroy or dispose, of those portions of documents and other materials in any form, including electronic form, prepared by or received by the Employer or its vendor or designee, that contain or reflect such PBM Proprietary Information or other Confidential Information. Employer, or its vendor or designee, shall certify such return and destruction, as the case may be, to CHLIC.

Appendix B - Cigna Home Delivery Pharmacy Specialty Drug List

THIS SPECIALTY DRUG LIST IS CONFIDENTIAL, PROPRIETARY INFORMATION OF CHLIC. IT IS PROVIDED SOLELY FOR EMPLOYER'S PLAN ADMINISTRATION PURPOSES. RE-DISCLOSURE IS STRICTLY PROHIBITED EXCEPT AS OTHERWISE PROVIDED BY APPLICABLE LAW. CHLIC RESERVES ALL LEGAL RIGHTS AND REMEDIES TO ENFORCE THESE PROHIBITIONS ON USE AND DISCLOSURE.

The Specialty Drug List shall be provided separately to Employer, and is hereby incorporated into the Agreement by reference, inclusive of any changes made subsequent to CHLIC's initial issuance of the Specialty Drug List to Employer to the pharmaceutical products included on the Specialty Drug List or the discounts pertaining to such pharmaceutical products. Upon Employer's request on or after the Effective Date, CHLIC shall provide to Employer an updated Specialty Drug List.

Currently Marketed Specialty Drugs on this Specialty Drug List. The discounts in this Specialty Drug List are the discounts that will be adjudicated in CHLIC's claim processing system for the drug indicated when dispensed by Cigna Home Delivery Pharmacy, subject to all of the following.

- Any or all of the discounts in this Specialty Drug List may be adjusted by CHLIC to the extent reasonably necessary to preserve the economic value of this Agreement as it existed immediately prior to the occurrence of any of the following events: a major change in market conditions affecting the pharmaceutical or pharmacy benefit management market, a drug shortage in the market, an issue involving the safety of the drug supply, or similar market situation.
- The discounts in this Specialty Drug List are based on the terms and design of the Pharmacy Benefit that Employer has adopted and disclosed to CHLIC. Accordingly, if Employer fails to disclose to CHLIC, for example, that it uses or intends to use a consumer-driven health plan, a major cost-sharing program, or a utilization management program promoting generic or OTC drugs over brand drugs, CHLIC may adjust the discounts as it reasonably deems necessary to preserve the economic value or benefit of this Agreement as CHLIC anticipated based on the terms and design of the Pharmacy Benefit previously disclosed to CHLIC and prior to CHLIC's discovery of the Pharmacy Benefit design feature that materially impacts CHLIC's discounts in this Specialty Drug List.
- The discounts in this Specialty Drug List shall not apply to Compound Drug claims, Claims that process at U&C, and direct member reimbursement (DMR) Claims.
- Any or all of the discounts in this Specialty Drug List may be adjusted by CHLIC to the extent reasonably necessary to preserve the economic value of this Agreement as it existed immediately prior to the occurrence of any of the following events: (a) there are any significant changes in the composition of CHLIC's pharmacy network or in CHLIC's pharmacy network contract compensation rates, or the structure of the pharmacy stores/chains/vendors that are contracted with CHLIC, including but not limited to disruption in the retail pharmacy delivery model, or bankruptcy of a chain pharmacy; or (b) there is a change in government laws or regulations which has a significant impact on pharmacy claim costs; or (c) any material manufacturer-rebate contracts with or for the benefit of CHLIC are terminated or modified in whole or in part; or (d) there is any legal action or Law that materially affects or could materially affect the manner in which CHLIC's rebate program is administered or an existing Law is interpreted so as to materially affect or potentially have a material effect on CHLIC's administration of the Pharmacy Benefit; or (e) there is a material change in the Plan or the Plan's Pharmacy Benefit that is initiated by Employer which impacts CHLIC's costs.

New-to-Market Specialty Products. Specialty Drug Claims that are for new-to-market drugs will have a minimum market-introduction guaranteed discount of 11.45% off the drug's AWP.

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')

Attached to and made part of Group Policy No. 3338881

It is hereby agreed that said policy is amended as follows:

- Page CSL-Policy(07-17) headed COVERAGE INFORMATION is deleted and the attached Pages headed COVERAGE INFORMATION is substituted therefore.

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')
Schedule of Insurance

Coverage Information

Policyholder:	City of Santa Fe
Policy Number:	3338881
Effective Date of this Amendment:	July 01, 2018
Issue Date:	June 04, 2018
Next Renewal Date:	July 01, 2019
State or other Jurisdiction of Issue:	New Mexico

Notices

For the purpose of any notices required under this policy, such notices should be sent to the addresses shown below:

Cigna Health and Life Insurance Company
900 Cottage Grove Road, Hartford, CT 06152
Attn: Stop Loss Unit

City of Santa Fe
200 Lincoln Ave
Santa Fe, NM 87501
Attn: Vicki Gage
vlgage@santafenm.gov
505-995-6595

Notice to Policyholder *- ADDITIONAL PROGRAMS* – Cigna may, from time to time, offer or arrange for various entities to offer discounts, benefits, services or other consideration to the Policyholder's employees for the purpose of promoting their general health and well-being. For details about these programs, contact Cigna. Any such consideration shall be provided by Cigna in connection with its administrative services agreement for the administration of the Policyholder's self-insured Plan and shall not be considered a benefit of this policy nor create any relationship between Cigna and the Policyholder's employees with respect to this policy.

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')

Individual Stop Loss Coverage

Policy Year:	July 01, 2018 to June 30, 2019
Covered Expenses:	Claims that are Incurred between July 01, 2014 and June 30, 2019 and that Become Due between July 01, 2018 and June 30, 2019

Monthly Premium Rates:
For each covered employee $78.44

Individual Stop Loss Benefit Percentage Payable: 100%

Individual Stop Loss Limit: $250,000.00

The following Covered Persons have been identified as High Risk Individuals and shall be subject to the Individual Stop Loss Limit as specified below:

High Risk Individuals None

Benefit Plans Covered by Individual Stop Loss Coverage:

Claim Administrator	Product
Cigna	HRA Open Access Plus
Cigna	Mental Health/Substance Use Disorders
Cigna	Open Access Plus
Cigna	Pharmacy Expense

Cigna's Maximum Liability per individual: Will be the individual maximum, if any, as set forth in the Benefit Plan less the Individual Stop Loss Limit

Additional exclusions from Individual Stop Loss coverage under this policy:

- Funds contributed by the company or an employee as part of a Health Reimbursement Account, Health Savings Account or Flexible Spending Account.
- Expenses resulting from fixed, per person, per period charges (fixed charges), if any, i.e., contractually determined periodic payments to certain providers based on the number of Plan participants entitled to receive services from the provider, in return for which, such providers furnish certain agreed-upon services to Plan participants.
- All Retirees

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')

Aggregate Stop Loss Coverage

Policy Year: July 01, 2018 to June 30, 2019

Covered Expenses: Claims that are Incurred between July 01, 2014 and June 30, 2019 and that Become Due between July 01, 2018 and June 30, 2019

For purposes of Aggregate Stop Loss, amounts attributable to claim base state surcharges, covered lives assessment and cost containment fees, as applicable, shall not be considered to be an excluded expenses of the Policyholder or Claim Administrator and as such shall be considered Covered Expenses.

Monthly Premium Rates:
For each covered employee $4.93

Aggregate Stop Loss Benefit Percentage Payable: 100%

Aggregate Individual Stop Loss Limit: $250,000.00

Benefit Plans Covered by Aggregate Stop Loss Coverage:

Claim Administrator	Product
Cigna	HRA Open Access Plus
Cigna	Mental Health/Substance Use Disorders
Cigna	Open Access Plus
Cigna	Pharmacy Expense

Cigna's Maximum Liability for the Aggregate Stop Loss coverage: Unlimited for the Policy Year

Corridor Factor: 125%

Minimum Attachment Point: $24,890,778.75

Minimum Attachment Percentage: 100%

Minimum Attachment Lagged Month: Two Months prior to the Policy Year's first Policy Month

Lagged Month: Two Months Prior

Monthly Attachment Factor (for each Covered Person):

Claim Administrator	Product	
Cigna	HRA Open Access Plus	$1,198.36
Cigna	OAP - OAPC, OAPC2	$1,612.26
Cigna	OAP - OAPP, OAPP2	$1,693.46

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')

Additional exclusions from Aggregate Stop Loss Coverage:

- Funds, if any, contributed by the company or an employee as part of a Health Reimbursement Account, Health Savings Account or Flexible Spending Account.
- All Retirees

Payment of premium is considered acceptance of this policy and the terms within.

ITEM # 19-0545

Victoria A. Sirica
Contractual Agreement Unit Manager
Cigna

May 30, 2019

Routing B2CAU
900 Cottage Grove Road
Hartford, CT 06152
Telephone 860.226.2785
Facsimile 860.730.3944
Victoria.sirica@cigna.com

Bernadette Salazar
Director, Human Resources
City of Santa Fe
200 Lincoln Ave
Santa Fe, NM 87501

RE: Administrative Services Only Account No. 3338881

Dear Bernadette Salazar:

This letter will serve as an amendment to the Administrative Services Only Agreement between Cigna Health and Life Insurance Company ("**CHLIC**") and City of Santa Fe ("**Employer**"), effective July 1, 2015, (the "Agreement") and as amended July 1, 2016 and July 1, 2017.

Effective as of July 1, 2019, 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.

"Run-Out Claims" in "Definitions," of the Administrative Services Only Agreement is hereby amended in its entirety as follows:

Run-Out Claims means claims for Plan Benefits relating to health care services and products that are incurred but not processed prior to termination of this Agreement; termination of a Plan benefit option or termination of eligible Members, as applicable.

Section 1, "Term and Termination of Agreement," of the Administrative Services Only Agreement, is hereby amended to add provision v. to the existing language as follows:

v. Notwithstanding the foregoing, all provisions in this Agreement reasonably related to CHLIC's administration of the Plan's Pharmacy Benefit (as such term is defined in Appendix A) (the "Pharmacy Benefit Provisions"), shall continue in effect for no less than thirty-six (36) months commencing on July 1, 2019, except that, if any of the following dates occurs, the Pharmacy Benefit Provisions set forth in the Schedule of Financial Charges and Appendix A will cease being in effect as of such date:

   a. The effective date of any Applicable Law or governmental action which prohibits performance of the activities in connection with the Pharmacy Benefit required by this Agreement;

   b. The date upon which Employer fails to fund the Bank Account as required by this Agreement for claims under the Pharmacy Benefit provided CHLIC notifies Employer of its election to terminate the Pharmacy Benefit Provisions;

   c. The date upon which Employer fails to pay CHLIC any charges in connection with the Pharmacy Benefit identified in this Agreement when due, provided CHLIC notifies Employer of its election to terminate the Pharmacy Benefit Provisions; or

"Cigna" is a registered service mark and the "Tree of Life" logo is a service mark of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Cigna Health and Life Insurance Company, Cigna Health and Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

d. The date that is sixty (60) days after notice by either Employer or CHLIC ("non-defaulting party") of the material breach by the other (the "defaulting party") of a material obligation of the defaulting party related to the Pharmacy Benefit (other than failure to fund the Bank Account or failure to pay any charges when due pursuant to Sections 1.v.b and 1.v.c above) that is not cured to the reasonable satisfaction of the non-defaulting party within a reasonable time following the initial notice of breach.

During such thirty-six (36) month period (or shorter period, as applicable under (a), (b), (c) or (d) above), CHLIC will continue to be the exclusive provider of Pharmacy Benefit administration services for the Plan's Pharmacy Benefit.

In the event that Employer purports to terminate such arrangement or enters into an agreement with another pharmacy benefit manager ("PBM") or other third party to provide any or all pharmacy benefit management services for Employer's benefit plan prior to the end of such thirty-six (36) month period, then, within thirty (30) days of CHLIC's written request, Employer shall pay CHLIC the amount of $1.50 per the average monthly number of Members who were enrolled in the Plan's Pharmacy Benefit from the beginning of the thirty-six (36) month period to the effective date of such purported termination or other agreement multiplied by the number of months remaining until the end of the thirty-six (36) month period. However, if Employer terminates its CHLIC medical coverage under this Agreement, no such fee shall apply.

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

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

Sections 5.a and 5.c of the Administrative Services Only Agreement are hereby amended in their entirety as follows:

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

c. Reconciliation of Eligibility and Information and Default Terminations. CHLIC will periodically share potential discrepancies in eligibility information with Employer. Employer will review and reconcile any discrepancies within thirty (30) days of receipt and provide CHLIC corrected eligibility information. If Employer fails to timely do so, CHLIC may terminate coverage for any Member not listed as eligible in Employer's submitted eligibility information.

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

The terms of the Administrative Services Only Agreement identified above, as mentioned herein, will be effective as of July 1, 2019. Please indicate your agreement to the amendment by signing the enclosed copy of this letter where indicated and returning it to me. Alternatively, this amendment shall become effective on the effective date indicated unless Employer notifies CHLIC either electronically or in writing (at the address indicated above) within sixty (60) days of the date of this letter that it does not accept all the terms of this amendment notwithstanding any provision to the contrary in the Administrative Services Only Agreement. In that case, CHLIC shall cooperate to negotiate mutually agreeable terms with Employer. Once agreement with respect to the terms of the amendment is reached, the amendment will apply retroactively to the effective date.

Sincerely,

7/10/2019

Victoria A. Sirica
Its Contractual Agreement Unit Manager
Duly Authorized
Cigna Health and Life Insurance Company

Accepted by: **City of Santa Fe**

By: _____

Name: _____

Title: _____

Executed this ____ day of _____, in the year _____

IN WITNESS WHEREOF, the parties have executed this Administrative Services Only Agreement "Amendment" on the date set forth below.

CITY OF SANTA FE:

ALAN WEBBER, MAYOR

DATE: 6/28/19

CONTRACTOR:
CIGNA

NAME & TITLE Victoria A Sirna Contractual Agreement unit manager

DATE: 7/10/2019

ATTEST:

YOLANDA Y. VIGIL, CITY CLERK
CC mtg 6.26.2019

APPROVED AS TO FORM:

6/13/19

ERIN K. MCSHERRY, CITY ATTORNEY

APPROVED:

MARY MCCOY, FINANCE DIRECTOR

Business Unit Line Item
62107.510300
62107.555700
62107.555750
62120.510300

Appendix A

Schedule of Financial Charges

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

MEDICAL/DENTAL ADMINISTRATION CHARGES		
Product	**Description**	**Charge**
Medical	HRA Open Access Plus (OAP) with Care Management Preferred (All Plans)	**$46.40/employee/month**
Medical	Open Access Plus (OAP) with Care Management Preferred (All Plans)	**$41.26/employee/month**
Dental	Dental Preferred Provider Organization (DPPO)	**$3.67/employee/month**
MEDICAL/DENTAL NETWORK ACCESS FEE, UTILIZATION MANAGEMENT FEE AND OPTIONAL PROGRAM FEE		
Product	**Description**	**Charge**
Medical	HRA OAP Access Fee (All Plans)	**$24.14/employee/month Included in Medical Administration Charge**
Medical	OAP Access Fee (All Plans)	**$24.14/employee/month Included in Medical Administration Charge**
Dental	DPPO Access Fee	**$0.86/employee/month Included in Dental Administration Charge**

	CIGNA CHOICE FUND AND OTHER CONSUMER DIRECTED ACCOUNT ADMINISTRATION SERVICES AND CHARGES	
	Product	**Charge**
	• Cigna Choice Fund Health Reimbursement Account (HRA) Administration	**For HRA OAP Products: $5.14/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. • 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 • Support of Participants identified through predictive modeling with certain preference sensitive care conditions by supplying impartial evidence based medical information, to empower Participants to understand the potential benefits/ disadvantages of a specific course of action and make more informed care decisions. • Answering health and medical related questions • Counseling Participants on prevention and the benefits of compliance with prescribed medications and treatments	**For HRA OAP Only: Included in Medical Access Fee**

	• Dependent Care Flexible Spending Account (DFSA) Administration	**For DFSA Products: Included at No Additional Cost**
	• Health Care Flexible Spending Account (FSA) Administration	**For FSA Products: $5.79/employee/month**

AMOUNTS PAID TO CHLIC

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

CIGNA PHARMACY BENEFIT MANAGEMENT FEES, CHARGES AND RELATED PROVISIONS

PHARMACY ADMINISTRATION FEE

Cigna Pharmacy Product Administration Fee, only if applicable, is separate from the Medical Administration Charge shown above, but included on same billing line as the Medical Administration Charge for billing purposes only.

CHARGES FOR COVERED DRUGS

Drugs Dispensed by Cigna Home Delivery Pharmacy: CHLIC will charge Employer for Covered Drugs dispensed to Members by Cigna Home Delivery Pharmacy based on the following charges, subject to the "PBM Pricing – Additional Provisions" section:

Brand Drug Claims: AWP minus an Actuarially Estimated average discount of 23.00%.

Generic Drug Claims: The Generic Drug's charge on a CHLIC MAC List which generates an Actuarially Estimated average discount on Generic Drugs across those CHLIC clients in the aggregate using such MAC List of AWP minus 84.00%.

Specialty Drug Claims: The Specialty Drug's charge discounted as shown in the Cigna Home Delivery Pharmacy Specialty Drug List, attached as Appendix B hereto.

Dispensing Fees for Both Brand Drug Claims and Generic Drug Claims: An average Dispensing Fee of no more than $0.00.

Covered Drugs Dispensed by Retail Pharmacies in 30-day* supplies: CHLIC will charge Employer for 30-day supplies of Covered Drugs dispensed by a Retail Pharmacy based on the following charges, subject to the "PBM Pricing – Additional Provisions" section:

***A 30-day supply means any Covered Drug dispensed by a Retail Pharmacy in an amount less than an 83-day supply.**

Brand Drug Claims: The lesser of (i) AWP minus an Actuarially Estimated average discount of 19.20%; or (ii) the Retail Pharmacy's U&C

Charge.

Generic Drug Claims: The lesser of: (i) the Generic Drug's charge on a CHLIC MAC List which generates an Actuarially Estimated average discount on Generic Drugs across those CHLIC clients in the aggregate using such MAC List of AWP minus 81.25%; or (ii) the Retail Pharmacy's U&C Charge.

Specialty Generic Drug Claims: The Specialty Generic Drug's charge discounted as shown in the Specialty Drug List, attached as Appendix B hereto.

Dispensing Fees for Both Brand Drug Claims and Generic Drug Claims: An Actuarially Estimated average Dispensing Fee of no more than $1.10, except in the case of Claims adjudicated at the U&C Charge, for which no separate Dispensing Fee is charged.

Covered Drugs Dispensed by Retail Pharmacies: CHLIC will charge Employer for Claims for Covered Drugs dispensed by Retail Pharmacies regardless of days' supply based on the following charges, subject to the provisions in the section titled "PBM Pricing - Additional Provisions":

Specialty Brand Drug Claims: The lesser of (i) AWP minus an Actuarially Estimated annual average aggregate discount of 11.50%; or (ii) the Retail Pharmacy's U&C Charge.

Covered Drugs Dispensed by Retail Pharmacies in 90-day supplies:** CHLIC will charge Employer for 90-day supplies of Covered Drugs dispensed by a Retail Pharmacy based on the following charges, subject to the "PBM Pricing – Additional Provisions" section:

****A 90-day supply means any Covered Drug dispensed by a Retail Pharmacy in an amount equal to or greater than an 83-day supply.**

Brand Drug Claims: The lesser of (i) AWP minus an Actuarially Estimated average discount of 23.00%; or (ii) the Retail Pharmacy's U&C Charge.

Generic Drug Claims: The lesser of: (i) the Generic Drug's charge on a CHLIC MAC List that generates an Actuarially Estimated average discount on Generic Drugs across those CHLIC clients in the aggregate using such MAC List of AWP minus 84.00%; or (ii) the Retail Pharmacy's U&C Charge.

Specialty Generic Drug Claims: The Specialty Generic Drug's charge discounted as shown in the Specialty Drug List, attached as Appendix B hereto.

Dispensing Fees for Both Brand Drug Claims and Generic Drug Claims: An average Dispensing Fee of no more than $0.00, except in the case of Claims adjudicated at the U&C Charge, for which no separate Dispensing Fee is charged.

PBM PRICING – ADDITIONAL PROVISIONS

- The amount paid by CHLIC to the Retail Pharmacy for Claims for Covered Drugs may or may not be equal to the amount charged to Employer and/or Member, and CHLIC will absorb or retain any difference.
- For a specific Claim for a Covered Drug dispensed by a Retail Pharmacy or Cigna Home Delivery Pharmacy, and after application of any

Plan cost-share requirements, CHLIC shall charge the Employer the lowest of the following amounts:

(1) The Prescription Drug Charge; or

(2) The pharmacy's submitted U&C Charge, if any.

- For a specific Claim for a Covered Drug dispensed by a Retail Pharmacy or Cigna Home Delivery Pharmacy, CHLIC shall charge the Member in accordance with the terms of the Pharmacy Benefit. For example, for a Covered Drug subject to a fixed dollar copayment requirement, CHLIC shall charge the Member the lowest of the following amounts:

  (1) The fixed dollar copayment for the Covered Drug, if any;

  (2) The Prescription Drug Charge; and

  (3) The pharmacy's submitted U&C Charge, if any.

- Unless specifically noted herein, the discounts to Employer for Covered Drugs set forth in this Agreement are not guaranteed to result in an average aggregate discount off the aggregate AWP of all such Covered Drugs.

- Any pricing guarantees, including any ingredient cost discount or Dispensing Fee guarantee, set forth in this Agreement shall be rendered null and void in the event Employer terminates CHLIC's administration of the Pharmacy Benefit prior to completion of the then-current Plan Year. CHLIC's fees, Rebates (if any), discounts or guarantees (if any) are, among other conditions communicated in this Agreement or otherwise in writing to Employer, contingent on, and assume, adoption by Employer of a specific Formulary, Retail Pharmacy network, and Plan design features (e.g. cost-share structure, utilization/cost management programs).

- Notwithstanding any other provision of this Agreement, CHLIC may, effective upon written notice to Employer, adjust any or all of the fees, Rebates (if any), discounts or guarantees (if any) in this Agreement to the extent reasonably necessary to preserve the economic value of this Agreement to CHLIC as it existed immediately prior to any of the following events or changes: (a) there are any significant changes in the composition of the CHLIC pharmacy network utilized by Employer hereunder or in such pharmacy network's contract compensation rates, or the structure of the pharmacy stores/chains/vendors that are contracted with CHLIC, including but not limited to disruption in the retail pharmacy delivery model, or bankruptcy of a chain pharmacy; or (b) there is a change in government laws or regulations which has a significant impact on pharmacy claim costs; or (c) any material manufacturer-rebate contracts with, or for the benefit of, CHLIC are terminated or modified in whole or in part; or (d) there is any legal action or law that materially affects, or could materially affect the manner in which CHLIC's rebate program is administered or an existing law is interpreted so as to materially affect or potentially have a material effect, on CHLIC's administration of the Plan; (e) a major change in market conditions affecting the pharmaceutical or pharmacy

benefit management market, a drug shortage in the market, an issue involving the safety of the drug supply, an unexpected introduction of a new drug (e.g. authorized generic), or similar market event occurs; (f) the Pharmacy Benefit enrollment decreases by equal to or greater than 15% from the enrollment on which CHLIC's financial offer is based; or (g) there is material change in the Plan that is initiated by Employer (and which CHLIC agrees to administer) such as a change in Formulary selection or network, or Employer fails to disclose a material feature of the Plan or the Plan's Pharmacy Benefit.

DRUG MANUFACTURER-PAYMENT SHARING

Subject to the caveats below, CHLIC will remit to Employer the following portion of Rebates that CHLIC collects with respect to utilization of Covered Drugs under the Plan's Pharmacy Benefit:

For All Products:

$75.00 per Retail Pharmacy Brand Drug Claim dispensed in a 30-day* supply, $180.00 per Retail Pharmacy Brand Drug Claim dispensed in a 90-day** supply and $350.00 per Cigna Home Delivery Pharmacy Brand Drug Claim.

Caveats:

(1) Upon termination of this Agreement, CHLIC may use Rebates otherwise payable to Employer to offset payable Bank Account Payments or other payable fees or changes identified in this Agreement. CHLIC may also use Rebates otherwise payable to Employer to offset any stop-loss reimbursement payments payable by CHLIC or its affiliate to Employer under a stop-loss policy issued to Employer.

(2) Should Employer terminate this Agreement before completion of the then-current Plan Year, no Rebates shall be due with respect to that Plan Year, and any Rebate minimum or fixed dollar guarantees shall be null and void, as payments of Rebates is conditioned on CHLIC exclusively administering the Pharmacy Benefits for the entire Plan Year.

(3) For percentage-based sharing arrangements, payout amount may differ slightly from the stated percentage when payout occurs before manufacturers' final reconciliations and payments are made to CHLIC. For the purposes of clarity, CHLIC shall reconcile its performance with respect to any Rebate payment guarantees, including, without limitation, any minimum or fixed dollar guarantees, in the aggregate.

(4) CHLIC or its agent contracts with drug manufacturers on CHLIC's own behalf, and not as agent of the Employer or the Plan.

(5) The Rebate payment commitments, including any minimum or fixed dollar guarantees, if any, set forth in this Schedule of Financial Charges are, among any other conditions communicated in this Agreement or otherwise in writing to Employer, contingent on the availability of Rebates to CHLIC and Employer's Pharmacy Benefit applying a 90-day supply limit for Specialty Drugs. For example, in the event that Employer has adopted, or adopts, a 30-day supply limit for Specialty Drugs, CHLIC shall revise the stated Rebate minimum

or fixed dollar guarantees, if any, to the extent necessary to reflect CHLIC's revised estimate of Rebates it may collect on Specialty Drugs utilized under the Pharmacy Benefit.

Timing of Rebate Pay-Out: Remittance will be provided within ninety (90) days after the close of each applicable calendar year for the portion of such calendar year that coincides with the Plan Year.

REBATE PAYMENT EXCLUSIONS

Any Rebate payment obligations exclude the following types of Claims and/or products:

- Compound Drugs.
- Claim reversals.
- Products identified as prescriptions covered under the federal 340B drug pricing program. Employer shall be solely responsible for ensuring that any pharmacy affiliated with or operated by Employer or its affiliate, such as an in-house pharmacy, systematically identifies 340B prescriptions on Claim transactions administered by CHLIC. If such pharmacy fails to systematically identify 340B prescriptions on Claim transactions submitted to CHLIC, then CHLIC may withhold all Rebates, or modify any minimum or fixed dollar Rebate guarantee, otherwise attributable to utilization at such pharmacy.
- Run-Out Claims.

CIGNA HOME DELIVERY PHARMACY DISCLOSURE		
	Product	**Charge**
Cigna Home Delivery Pharmacy (a CHLIC affiliated company)	Specialty drugs dispensed by Cigna Home Delivery Pharmacy and administered under the Plan's medical benefit. Cigna Home Delivery Pharmacy and any other licensed pharmacy affiliate of CHLIC may maintain product purchase discount arrangements and/or fee-for-service arrangements with pharmaceutical manufacturers and wholesale distributors. Cigna Home Delivery Pharmacy or any other licensed pharmacy affiliate of CHLIC contract for these arrangements on its own account in support of its pharmacy operations. These arrangements relate to services provided outside of this Agreement and other pharmacy benefit management arrangements and may be entered into without regard to whether a specific drug is on one of the formularies that CHLIC offers to entities like Employer that sponsor group health plans. Discounts and fee-for-service payments received by Cigna Home Delivery Pharmacy or any other licensed pharmacy affiliate of CHLIC are not part of the administrative fees or other charges paid to CHLIC in connection with CHLIC's services hereunder. This provision shall survive termination or expiration of the Agreement.	**The drug's charge under a national specialty drug discount schedule that generates a 12.5% annual average aggregate discount off AWP across specialty drug claims dispensed at Cigna Home Delivery Pharmacy to CHLIC's self-funded and insured group-client book of business.**
FEES FOR PROCESSING RUN-OUT CLAIMS		
HRA OAP, OAP and DPPO	Run-Out Period of twelve (12) months	**No Additional Cost**
Pharmacy	Run-Out Period of three (3) months for all pharmacy claims	**No Additional Cost**

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

CHLIC MEDICAL COST CONTAINMENT FEES

CHLIC administers the programs listed below to contain costs with respect to charges for health care service/supplies that are covered by the Plan (the "**Cost-Containment Programs**"). In administering these Cost-Containment Programs, CHLIC may contract with vendors to perform various Cost-Containment Program related services. Vendor fees generally range from 7-11% of gross savings. Specific vendor fees are available upon request subject to execution of a mutually agreed upon non-disclosure agreement to protect the proprietary vendor fee information from unauthorized use/disclosure. CHLIC's charge for administering a Cost-Containment Program is the percentage indicated below of either: (1) the "gross savings" (i.e., the difference between the charge the provider would have made and the charge the provider actually made as a result of the Cost-Containment Program). Any applicable vendor fee is included in CHLIC's charge and paid to the vendor by CHLIC; or (2) the "net savings" (i.e., the gross savings less the applicable vendor fee). With respect to only the "recovery," any applicable vendor fee is included in CHLIC's charge and paid to the vendor by CHLIC; or (3) the "recovery" (i.e., the amount recovered as a result of the Cost-Containment Program). Any applicable vendor fee is included in CHLIC's charge and paid to the vendor by CHLIC.

For charges for covered services received from a non-Participating Provider (including emergency/urgent care services that are covered at the in-network benefit level), CHLIC may apply discounts available under agreements with third parties or through negotiation of the non-Participating

Provider's charges whether on a claim-by-claim basis or in advance of services being rendered. These programs are identified below as the Network Savings Program Supplemental Network, and Medical Bill Review (pre-payment). CHLIC charges the percentage shown for administering these programs. Applying these discounts may result in higher payments than if the maximum reimbursable charge is applied. Whereas application of the maximum reimbursable charge may result in the patient being balance billed for the entire unreimbursed amount, applying these discounts avoids balance billing and substantially reduces the patient's out-of pocket cost.

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

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

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

a. the amount of provider's billed charge not exceeding the greater of a CHLIC determined percentage of the Medicare allowable amount (the 80th percentile of the reasonable and customary charge if there is no Medicare allowable charge) or the amount required by state or federal, law (in the case of emergency room services) for charges subject to CHLIC's benefit enhancement policy (patient may be balance billed by the provider if the provider's charge exceeds such amount), or

b. the provider's billed charge.

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

1.	Network Savings Program	**29% of net savings**
2.	Supplemental Network	**29% of net savings**
3.	Medical Bill Review – (Pre-payment Cost Containment for Non-contracted claims):	
	Inpatient Hospital Bill Review	
	• Line Item Analysis	**Lesser of 5% of hospital bill or the gross savings achieved**
	• Professional Fee Negotiation	**29% of net savings**
	Outpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**

	• Line Item Analysis Re-pricing	**29% of net savings**
	Physician/Professional Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
4.	Medical Bill Review – (Pre or Post-payment Cost Containment for Non-contracted and Contracted claims):	
	• Bill Audit	**29% of the gross savings/recovery achieved plus hospital fees or expenses passed through**
	Diagnosis Related Grouping (DRG) Validation/Audits and Recovery. An overpayment audit and recovery program in which CHLIC or its vendors review paid claim data to identify overpayments based on inaccurate DRG coding.	**29% of recovery plus any fees or expenses passed through by the hospital or regulatory agency**
	Medical Implant Device Audits	**29% of recovery**
5.	COB Vendor Recoveries [Exclusive of pharmacy programs where claims are adjudicated at time prescription is received.]	**29% of recovery**
6.	Secondary Vendor Recovery Program	**29% of recovery**
7.	Provider Credit Balance Recovery Program	**29% of recovery**
8.	High Cost Specialty Pharmaceutical Audits (this service is only provided with respect to Medical coverage)	**29% of recovery**
9.	Class Action Recoveries	**35% of recovery**
10.	Eligibility Overpayment Recovery Vendor Services. Identification and recovery of funds in situations where the overpayment is due to the late receipt of Member termination information. (This service is only provided with respect to Medical coverage).	**29% of recovery**

CHLIC PHARMACY COST CONTAINMENT FEES		
CHLIC administers the following programs to contain costs with respect to charges for health care service/supplies that are covered by the Plan. In administering these programs, CHLIC contracts with vendors to perform program related services. CHLIC's charge for administering these programs is the percentage (indicated below) of the "recovery" (i.e. the amount recovered) as applicable.		
1.	Pharmacy Vendor Recoveries. CHLIC performs periodic audits of contracted pharmacies in order to determine the accuracy of payments to the pharmacy(ies). CHLIC's recovery vendor collects and remits to CHLIC all overpayments to pharmacy(ies), and CHLIC remits to Employer's Bank Account the balance collected from the recovery vendor, less the recovery fee set forth herein.	**30% of recovery**
2.	Class Action Recoveries. CHLIC identifies, monitors and may participate, on behalf of Employer, in class action lawsuits or similar legal proceedings against pharmaceutical manufacturers. CHLIC collects and retains as a recovery fee set forth herein of any recovery (net of attorneys' fees) attributable to Employer's Plan.	**35% of recovery**
CHLIC DENTAL COST CONTAINMENT FEES		
Dental Cost Containment	CHLIC administers the following program to contain costs with respect to charges for dental services that are covered by the Plan. Applies to 2nd tier of participating DPPO network providers and includes: • Access to an additional network of DPPO dentists who provide care at a discounted rate. Lower out-of-pocket expenses for Members and additional claim savings for Employer when receiving covered services from these DPPO dentists. • CHLIC retains the percentage identified herein of Employer and/or Member gross savings for access and to cover the 2nd tier network administrative cost. • CHLIC calculates the percentage identified herein as fees charged on a pay-as-you save basis. If there is no savings, there is no fee charged to Employer. Gross savings are calculated by taking what the dental professional would have charged if not participating in the network minus the dentist's contracted fee. The dental cost containment fee is charged to Employer via the appropriate Electronic Funds Transfer (EFT) cycle as a percent of the savings assessed weekly against the Bank Account and would appear on Bank Account activity report(s) as Vendor Fee Reimbursement.	**For DPPO Products: 25% of gross savings**

	CARE MANAGEMENT (CM) / CONSIGNMENT PROGRAM FEES	
	CHLIC arranges for third parties to provide care management services to: (i) contain the cost of specified health care services/items overall with respect to all plans insured and/or administered by CHLIC, and/or (ii) improve adherence to evidence based guidelines designed to promote patient safety and efficient patient care.	**Specific vendor fees and care management program services are available upon request.**
	EXTERNAL REVIEW AND CONSULTATIVE REVIEW FEES	
	When a Member elects an External Review (as that term is defined in ERISA) of a benefit determination by an independent third party, the cost of a specific third party review is dependent on the nature and complexity of the issue on appeal. In highly complex, non-routine cases or cases related to new technology or experimental-investigational treatment, as part of the internal appeal process a panel of external reviewers may be necessary. Third party review charges will be commensurate with the number of reviewers (usually only one is used), as well as their level of expertise and time required to complete the review.	**$500-$4,000 Review**
	STRATEGIC ALLIANCES	
	CHLIC contracts directly or indirectly with other managed care entities and third party network vendors for access to their provider networks and discounts. These third parties charge either a network access fee, which is included in CHLIC's monthly charges, or a percentage of the savings realized on a claim by claim basis as a result of the application of their discounts. Charges based on percentage of savings may be paid from the Bank Account. Additional details regarding specific charges will be provided upon request.	**All Medical Products**
	OTHER VENDORS AND HEALTH CARE SERVICES PROVIDERS	
	Fixed per person per period and fee-for-service charges for various vendors and other providers/arrangers of health care services and/or supplies will be paid as claims for Plan Benefits. In addition, performance-based payments to Participating Providers will be charged to the Bank Account. Such payments will be at the payment rates then in effect, which may be amended from time to time. Additional details regarding charges and the identity of the vendor or provider of health care services will be made available upon request.	**All Products**

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

	administering the Plan.	
	COMPLIANCE ASSISTANCE	
	CHLIC shall provide the following services to assist Employer in meeting its compliance obligations under section 2715 of the Public Health Service Act as added by the Patient Protection and Affordable Care Act and applicable regulations with respect to the provision of the Summary of Benefits and Coverage ("**SBC**"), translation notice and glossary. Applicable to all medical plans including HRA and FSA which are considered "group health plans" subject to the SBC requirements.	
1.	Preparation of SBC, translation notice. CHLIC will not be responsible for any changes that Employer makes to the SBC.	**No charge**
2.	Provide SBC, translation notices prepared by CHLIC to Employer electronically as well as any updates or material modifications.	**No charge**
3.	Include in SBC a summary of benefits administered by carve-out vendor if Employer or carve-out vendor provides CHLIC with necessary carve-out benefit information at least twelve (12) weeks prior to the date the SBCs are to be delivered to Employer.	**$500 for each benefit option under the Plan for which carve-out vendor benefits are included in SBC**
	ADDITIONAL SERVICES	
Service	**Description**	**Charge**
Pharmacy Utilization Management Program	**Essential Package** - a utilization management program under which some pharmaceutical products are subject to one or several coverage limitations, including prior authorization, step therapy and/or quantity limits. Under a prior authorization requirement, the requested drug is generally reviewed for clinical appropriateness based on the intended use in therapy. Under a step therapy requirement, the Member generally must try one or more preferred products, or demonstrate why trying the preferred product(s) would be clinically inappropriate, in order to obtain coverage for the requested drug.	**For All Products: Included in Pharmacy Administration Fee**

Clinical Program	**Cigna TheraCare® Program** - a targeted condition drug therapy management program that supports individuals using specialty medications for certain chronic conditions and helps them better understand their condition, medication side effects and importance of adherence.	**For HRA OAP** **and OAP Products: Included at No Additional Cost**
Your Health First	A proactive health education and improvement program for Members with a chronic condition. The program involves services that span across the Member's health needs. Behavioral coaching principles and evidence based medicine guidelines are utilized to optimize self-management skills and foster sustained health improvements. The program targets a chronic population at high risk for near term and future high cost medical expenses. Members are identified as having a chronic condition through a variety of sources which may include: claims data, referrals, and self-identification. A variety of resources is provided to those with a chronic condition, including access to online tools, personalized support, and targeted materials. The program includes the following components for those with a chronic condition: • Chronic condition-specific coaching • Pre- and post-discharge calls • Lifestyle management coaching: stress, weight management and tobacco cessation • Treatment decision support and coaching In order to continuously assess the effectiveness of the program and/or test new ideas to further engage Members around their health, a small sample of Members may be placed in a comparison group which for a defined period of time receives alternative services or is suppressed from receiving proactive outreach, such as engagement letters and/or calls. This could affect a few Members targeted for outreach during this limited time period.	**For HRA OAP** **and OAP Products: Included in Medical Access Fee**

Claim Litigation	Claim Litigation Services	**$3,500.00 Flat Annual Amount Included in Medical Administration Charge**
Claim and Appeals	CHLIC will administer an optional second level of claim appeals	**$0.94/employee/year Included in Medical Administration Charge**
Internet-Based Enrollment and Eligibility Management System	CHLIC, either directly or through its affiliate, Cigna Benefit Technology Solutions, Inc., will grant to Employer and Participants a nontransferable limited license to access Cigna Guided Solutions, CHLIC's Internet-Based Enrollment and Eligibility Management System for online enrollment and selection of benefits. Products and services are outlined in the Employer Agreement provided to the Employer by Cigna. More specific information about the products, services, charges, grant of license and applicable restrictions are available upon request.	**Any fees payable will be in accordance with the separate Employer Agreement.**
One Guide	One Guide is an enhanced level of personalized benefit service which offers Members proactive, personalized guidance and a simplified Member experience. The One Guide solution combines human interaction- through One Guide agents- with a robust digital tool - through the myCigna native mobile app - so Members have quick, convenient access to personal benefit information, and can engage the way they prefer. The system simplifies and strengthens the connection between Members, their benefit plan, and their overall health and well-being. One Guide proactively engages Members with clear ways to save money, stay healthy, and improve health outcomes that lead to a healthy lifestyle. One Guide offers: • education on health plan features, account balances and ways to maximize benefits and earn available incentives • guidance in finding the right doctor, lab, convenience care or pharmacy • immediate connection to health coaches and other resources The goal of One Guide is to help Members take care of what matters most- staying healthy, saving money, and improving health.	**For HRA OAP** **and OAP Products: $3.50/employee/month Included in Medical Access Fee**

Health Improvement Fund		
Health Improvement Fund	For clinical/wellness/behavioral programs offered by CHLIC that are purchased, CHLIC will establish a Health Improvement Fund in the amount of $100,000.00. This fund will be used to defray the cost of CHLIC designated and arranged health and wellness improvement programs (e.g. biometric screenings, flu shots) for Employees of Employer and to reward participation in these programs. The Health Improvement Fund is a one-time credit to be used from July 1, 2019-June 30, 2020. Unused funds cannot be rolled over and CHLIC must pre-approve use of the Health Improvement Fund. The Health Improvement Fund shall be extinguished upon termination of this Agreement and any fund amount not used prior to termination of this Agreement shall only be available to Employer for the purpose of funding the cost of those reimbursable services provided prior to such termination.	

Exhibit B – Services

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

	Perform, based on CHLIC's book of business internal audits of plan benefit payments on a random sample basis.	**All Products**
	Claim control procedures reported annually in Statement on Standards for Attestation Engagements (SSAE) No. 18 Report (or any applicable successor thereto).	**All Products**
	Respond to Insurance Department complaints.	**All Products**
	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Products**
	Member Explanation of Benefit ("**EOB**") statements including, when applicable, notice of denied claims, denial reason(s) and appeal rights.	**All Products (excluding Pharmacy)**
	Verify enrollment and eligibility using Member information submitted by Employer and/or its authorized agent.	**All Products**
Medical Only		
	CHLIC's generic enrollment form is made available to Employer for individuals eligible to enroll in the Plan.	**All Medical Products**
	CHLIC's standard ID card with toll-free telephone number are prepared and mailed directly to Members.	**All Medical Products**
	Administration of subrogation/conditional Claim Payment (terms described in Exhibit E).	**All Medical Products**
Dental Only		
	CHLIC's generic enrollment form is made available to Employer for individuals eligible to enroll in the Plan.	**All Dental Products**
	CHLIC's generic ID cards are prepared and bulk shipped to the Employer's address to distribute to their employees.	**All Dental Products**
	Standard Dental predetermination of benefits for dental procedures on a voluntary basis.	**All Dental Products**
	When elected, the Cigna Oral Health Integration Program® (OHIP) includes the provision of administrative services necessary to provide eligible Members with certain health conditions enhanced dental benefits. The program covers the following conditions: Maternity, Diabetes, Cardiovascular Programs, cerebrovascular disease (stroke), chronic kidney disease, organ transplants and head/neck cancer radiation, and is aimed at improving overall health by encouraging Members to obtain needed dental treatment by providing enhanced benefits. As appropriate, OHIP may be expanded to include new procedures, conditions and programs in the future.	**All Dental Products**

Health Care Flexible Spending Account and Dependent Care Flexible Spending Account Only		
	Providing generic enrollment forms and reimbursement request forms to Employer for use in connection with Health Care Flexible Spending Account ("**FSA**") and/or Dependent Care Flexible Spending Account ("**DFSA**") under which eligible employees (collectively "**FSA Members**") may elect to reduce their salary on a pre-tax basis up to the IRS maximum contribution allowed for deposit into a FSA and/or DFSA.	**FSA and DFSA Products**
	At the end of each reimbursement period of the Plan Year, CHLIC shall issue payments to the extent that funds remain in each FSA Member's account, for the amount that is determined by it to be proper under the Plan. At the end of the final reimbursement period of the Plan Year, CHLIC shall issue payments for any amount then due for those expenses that are determined by it to be proper under the Plan.	**FSA and DFSA Products**
	Allowable expenses for reimbursement under a DFSA include all allowable expenses incurred for the care of dependents pursuant to I.R.C. Sections 125 and 129.	**DFSA Products**
	Allowable expenses for reimbursement under a FSA include all allowable health-related expenses, pursuant to I.R.C. Sections 125 and 213 except where reimbursement under a FSA is prohibited.	**FSA Products**
	FSA Member account balances will remain open after conclusion of the Plan Year until 9/30 (the "**Run Out Period**"), so that FSA Members can submit any remaining expenses incurred during the Plan Year. For employees enrolled in the FSA on the last day of the Plan Year, claims incurred in the first 2 ½ months following the end of the Plan Year can also be submitted during the Plan run out period and applied to Plan Year unused funds. Separate account balances will be maintained as per FSA Member's election for the new Plan Year.	**FSA and DFSA Products**
	Reimbursement requests of terminating FSA Members will continue to be processed for 90 days following termination of FSA Membership for any expenses incurred prior to the FSA Membership termination date. In the case of a DFSA, reimbursement will be up to the balance in the DFSA and in the case of a FSA, reimbursement will be to the originally selected goal amount, minus prior reimbursements, regardless of whether this amount has been funded.	**FSA and DFSA Products**
	For FSA payments that are not made with a Debit Card but are a result of automatic claim forwarding ("**AutoPay**") of medical or dental claims from a medical or dental plan administered by CHLIC or Direct Submit Request For Reimbursement, an explanation of payment will be mailed to the FSA Member at their home address or, if elected, provided electronically. An explanation of payment is not issued for FSA payments that are issued to a pharmacy at the point of service as a result of automatic claim forwarding from the employee's pharmacy Plan.	**FSA Products**

	For DFSA payments made as a result of a Direct Submit Request For Reimbursement, an explanation of payment will be mailed to the DFSA Member at their home address or, if elected, provided electronically.	**DFSA Products**
	An 800 number directly linked to CHLIC's Member Services will be available for FSA Members' questions and status inquiries. This 800 number will be listed in the instructions on the reimbursement request form as well as having access to account information via Internet.	**FSA and DFSA Products**
	The Employer will identify through eligibility submission, FSA Members who elect to have medical and pharmacy claims processed but unpaid by CHLIC automatically submitted ("**rolled over**") to their FSA. Such rollover claims will be processed without additional submissions by the FSA Member and CHLIC shall be entitled to rely on the Employer's submission of the FSA Member's rollover election that the submitted expenses were properly incurred, not reimbursable from any other source and are eligible for payment under the regulations governing flexible spending accounts.	**FSA Products**
	When CHLIC takes over a FSA administration mid-Plan Year, CHLIC will provide administration services from the date CHLIC receives the FSA Plan information for claims incurred anytime during the Plan year.	**FSA and DFSA Products**
	For Employees enrolled in a health care FSA plan with a debit card, a debit card will be issued to each FSA Member. (employees enrolled in both a health care FSA plan with a debit card and a Health Reimbursement Account plan with a debit card will only receive one debit card covering both plans.) The card is pre-loaded with the FSA Member's annual Health Care FSA goal amount for the Plan Year. Plan Year FSA funds are available using the debit card for transactions actually processed during the Plan Year period. The card does not access funds from a prior Plan period unless the Plan has the extended claim period and the Employee re-enrolls in the FSA for the subsequent period. If an Employee terminates their FSA Plan or does not re-enroll in the FSA, the debit card will be de-activated and will not be available for use after the last day of the Employee's FSA enrollment. The card is used by the FSA Member to access available FSA funds based upon the submitted goal amount less amount paid Plan Year to date from the fund. Since debits made with the card are not submitted by the card vendor to CHLIC in real-time but only on a daily basis, Employer agrees to fund all debits made by the FSA Member through the daily feed from the card vendor that indicates the FSA Member account is exhausted. The card is restricted to specific merchant types that are considered health care related. Although the card is limited to these types of merchants, the card does not limit specific items within these merchants. When the debit card is	**FSA Products**

	used, funds are automatically deducted from the FSA. FSA Members may be required to submit receipts to CHLIC to substantiate debit card expenditures. If appropriate substantiation is not received, the debit card will be suspended and no longer available for use.	
Health Reimbursement Account (HRA), Healthy Awards (HA) and Healthy Future (HF) Only		
	Providing reimbursement request forms to Employer.	**HRA Products**
	Employer will make available specific funds to eligible Employees enrolled in the HRA, HA and/or HF as applicable (**"Participating Members"**). At the end of each reimbursement period of the Plan Year, CHLIC shall issue payments to Participating Members (or their medical provider, if appropriate) to the extent of the maximum amount of payment allowed by Employer reduced by prior reimbursements for the same period of coverage, for the amount that is determined by it to be proper under the Plan.	**HRA Products**
	Allowable expenses for reimbursement under a HRA, HA and/or HF, as applicable, include all allowable health-related expenses, pursuant to I.R.C. Section 213 except where payment for any such products is prohibited. The Employer can further limit the allowable expenses as agreed to by the Employer during implementation.	**HRA Products**
	Account balances for Participating Members active until the end of the Plan Year will remain open after conclusion of the Plan Year for a period of 90 days, (the **"Run Out Period"**), so that such Participating Members can submit any remaining expenses incurred during the Plan Year.	**HRA Products**
	A Participating Member's request to terminate his/her enrollment in the HRA, HA, and/or HF, as applicable, will continue to be processed for 90 days following termination for any expenses incurred prior to his/her termination date up to the originally selected goal amount, minus prior reimbursements.	**HRA Products**
	For reimbursement payments that are made as a result of automatic claim forwarding (**"AutoPay"**) of medical claims from a medical plan administered by CHLIC or Direct Submit Request For Reimbursement, an explanation of payment will be made available to the Participating Member. An explanation of payment is not issued for payments that are issued to a pharmacy at the point of sale as a result of AutoPay from the Employee's pharmacy Plan or for any Debit Card transactions.	**HRA Products**
	Providing information on account balances and submitted claims to Participating Members calling the number on the ID card. In addition, Participating Members will have access to account information via Internet and mobile app.	**HRA Products**

	When automatic claim forwarding ("**AutoPay**") is turned on, medical claims processed but unpaid by CHLIC will be automatically submitted for reimbursement from the HRA and/or HA Participating Member's HRA and/or HA account. Such "rollover" claims will be processed without additional submissions by the Participating Member.	**HRA Products**
	When CHLIC takes over HRA, HA and/or HF administration mid-Plan Year, CHLIC will provide administrative services from the date the Plan information is received.	**HRA Products**
	For Employee enrolled in an HRA, HA and/or HF Plan with a debit card, a debit card will be issued to each HRA, HA and/or HF participating Employee and spouse (if spouse is enrolled in the Plan). A debit card will also be issued upon Employee request to other eligible dependents. (Employees enrolled in both a health care FSA Plan with a debit card and a Health Reimbursement Account Plan with a debit card will only receive one debit card covering both Plans.) The card is pre-loaded with the Participating Member's annual HRA, HA and/or HF goal amount for the Plan Year. If additional funds are added during the plan year, the card balance will automatically be adjusted. Plan Year HRA, HA and/or HF funds are available using the debit card for transactions actually processed during the Plan Year period. The card will access funds from a prior Plan period when the Employee re-enrolls in the HRA, HA and/or HF for the subsequent period and has remaining HRA, HA and/or HF funds that carry over to the new period, and the debit card was active for the prior plan period. If an Employee terminates their HRA, HA and/or HF Plan or does not re-enroll in the HRA, HA and/or HF the debit card will be de-activated and will not be available for use after the last day of the Employee's HRA, HA and/or HF enrollment. The card is used by the HRA, HA and/or HF Participating Member to access available HRA, HA and/or HF funds based upon the submitted goal amount plus any added incentive reward dollars (if applicable) less amount paid Plan Year to date from the fund. Since debits made with the card are not submitted by the card vendor to CHLIC in real-time but only on a daily basis, Employer agrees to fund all debits made by the Participating Member indicated through the daily feed from the card vendor, until the Participating Member's account is exhausted. The card is restricted to specific merchant types that are considered health care related based on service category elections. Although the card is limited to these types of merchants, the card does not limit specific items within these merchants, unless they are an inventory information approval system ("IIAS") merchant with The Special Interest Group for IIAS Standards ("SIGIS"). When the debit card is used, funds are automatically deducted from the HRA, HA and or HF. HRA, HA and/or HF Participating Members may be required to submit receipts to CHLIC to substantiate debit card expenditures. CHLIC will attempt to obtain the appropriate documentation from the participant via	**HRA Products**

	mail or email. If appropriate documentation to substantiate the transaction is not received, the debit card will be suspended and no longer available for use.	
	Pharmacy claims: Eligible pharmacy expenses, under the HRA and/or HA that are processed but unpaid by CHLIC may be automatically submitted ("rolled over") to the Reimbursement Accounts Claim Office for reimbursement from the Participating Member's HRA, HA and/or HF account if the AutoPay option is enabled. Such rollover claims will be processed without additional submissions by the Participating Member. When pharmacy is covered and Cigna Pharmacy is the pharmacy vendor, the HRA and/or HA will automatically pay the pharmacy through the HRA and/or HA at the point of sale for all Participating Member obligations under the pharmacy Plan including deductibles, copays, and/or coinsurance obligations. A Participating Member will not receive an Explanation of Benefits for these payments.	**HRA Products**
	PLAN BOOKLET	
	Products excluding Health Savings Account	
	Prepare and make accessible Member benefit booklet drafts to Employer.	**All Products**
	UNDERWRITING SERVICES	
	5500 Schedule C reporting.	**All Products**
	5500 Schedule A or Annual Reconciliation Disclosure reporting (when applicable)	**All Products**
	CHLIC's standard Underwriting services: a) benefit design analysis b) projected cost analysis.	**All Products**
	HIPAA AND DUAL RIGHTS	
	Products excluding Health Savings Account	
	Handling of requests from Members for access to, amendment and accounting of protected health information, and requests for restrictions and alternative communications as required under federal HIPAA law and regulations, as set out in this Agreement and its Exhibits.	**All Products**
	COST CONTAINMENT	
	Maximum reimbursable charge determinations of non-Participating Provider charges for covered services.	**All Medical Products (with out-of-network benefits)**
	CHLIC's standard cost containment controls: Application of non-duplication and coordination of benefits rules and coordination with Medicare.	**All Medical Products**
	Delivery of information, as necessary, regarding standard application of non-duplication or coordination of benefits.	**All Medical and Dental Products**

	Review of medical bills in accordance with CHLIC's then current Medical Bill Review program.	**All Medical Products**
	Dental Cost Containment, a network of additional participating PPO providers that provide discounts for which CHLIC retains a portion of the savings generated.	**All Dental Products**
	Network Savings Program, a national vendor network that provides discounted rates when a Member accesses care through a Network Savings Program contracted provider.	**All Medical Products**
	Annual reporting of CHLIC's standard cost containment results upon Employer's request.	**All Medical and Dental Products**
	Pharmacy Vendor Recoveries.	**All Pharmacy Products**
	CUSTOMER REPORTING	
	Summary reports of medical, dental and pharmacy cost and utilization experience (where applicable), upon completion of internal report generation, are available through Cigna's web site, CignaAccess.com.	**All Medical, Dental and Pharmacy Products**
	CHLIC's standard pharmacy utilization reports.	**Pharmacy Product Only**
	Claim Reporting: CHLIC will provide standard banking and financial report information based upon paid claim data. CHLIC will not provide information on incurred-but-not reported claims, projected claims, pre-certifications of coverage, case management information or information on a Member's prognosis or course of treatment. Stop Loss Reporting is an optional service provided at an additional fee to Employers who have stop loss through another entity other than CHLIC. CHLIC will provide its standard reporting only after the stop loss carrier and Employer have executed CHLIC's standard Hold Harmless/Confidentiality Agreement.	**All Medical Products**
	CHLIC's standard management and statistical reports for Employer.	**FSA and DFSA Products**
	CHLIC's standard Individual Summary Statements for applicable participating Members.	**FSA, DFSA and HRA Products**
	CHLIC's standard Health Reimbursement Account, Healthy Awards and/or Healthy Future activity report for Employer.	**HRA Products**
	COMPLIANCE	
	Employer directs CHLIC in administering the Health Care Flexible Spending Account, Healthy Awards, Healthy Futures and/or Health Reimbursement Account benefit to comply with COBRA as follows:	
	Each FSA Member who experiences a qualifying event and elects continuation of account	**FSA Products**

	coverage in accordance with COBRA will be maintained until the earlier of the end of the Plan Year, the exhaustion of the FSA balance or other termination of the FSA.	
	FSA Members electing continuation of FSA coverage under COBRA will continue contributions at a rate not to exceed 102% of the applicable premium. The Employer may require after-tax contributions, or may allow the continuant to elect a lump-sum salary reduction in the amount required in contributions for the remainder of the coverage period.	**FSA Products**
	FSA Members who continue under COBRA and whose contributions have been made as required may submit Reimbursement Requests for themselves and any eligible dependents, for expenses incurred before or after the date of the qualifying event but prior to the end of the coverage period. Requests may be submitted until the earlier of the end of the Plan Year or the termination of the FSA, including any applicable Run-Out Period.	**FSA Products**
	The HRA, HA and/or HF of each HRA, HA and/or HF Participating Member who experiences a qualifying event and elects continuation of account coverage in accordance with COBRA will be maintained similar to the maintenance of an active Employee. HF Participating Members that have not met their vesting requirements determined by the plan are not required to be offered COBRA for the HF.	**HRA Products**
	MEMBER EXTERNAL REVIEW PROGRAM	
	CHLIC contracts with a minimum of three (3) independent review organizations that meet the Patient Protection and Affordable Care Act (PPACA) external review requirements. Members may appeal eligible claims requiring medical judgment to an external independent review organization which is selected by CHLIC on a random basis. If Employer has chosen not to participate in this program, the Employer may be responsible for making other arrangements to meet the Patient Protection and Affordable Care Act (PPACA) external review requirements.	**All Medical Products**
	MEDICAL MANAGEMENT SERVICES	
	CHLIC provides integrated medical management that includes (depending upon the terms of the Plan) the following core services.	
	Pre-Admission Certification and Continued Stay Review (PAC/CSR) services to certify coverage of acute and sub-acute inpatient admissions/stays or provides guidance to appropriate alternative settings. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products**
	Case Management, a service designed to provide assistance to a Member who is at risk of developing medical complexities or for whom a health incident has precipitated a need for	**All Medical Products**

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

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

	CHLIC has contracted with an affiliate, Cigna Behavioral Health ("CBH"), to provide or arrange for the provision of managed in-network behavioral health services, CBH is a Participating Provider, and is reimbursed primarily on a monthly fixed fee basis. This fixed fee for CBH services will be paid as claims and will appear in Employer's monthly reporting and on financial documents. Such payments will be at the relevant monthly rates then in effect. The monthly rates paid to CBH vary depending on geographic location of Members and on benefit design, and may be subject to change. The rates will be made available upon request. The fixed fee also includes lifestyle management programs, a cognitive behavioral modification program, a Complex Psychiatric Case Management program, and a Narcotics Therapy Management program. Behavioral claims from a client specific network are not included in the behavioral monthly fixed fee and will be paid from the Bank Account. In some states, payment for behavioral health services must be paid on a fee-for-service basis. In these states, fee-for-service payments for behavioral health services and the CBH administrative fee (including the lifestyle management programs, a cognitive behavioral modification program a Complex Psychiatric Case Management program and a Narcotics Therapy Management program) will be paid from the Bank Account as claims and will appear in Employer's monthly reporting.	**These services are included in the following products:** **HRA OAP** **and OAP Products**
	CIGNA STAFF MODEL HEALTHPLAN SERVICES	
	The Cigna HealthCare of Arizona, Inc. staff model ("**Cigna Medical Group**") is a Participating Provider located in metropolitan Phoenix, Arizona. Plan Participants may at some time receive treatment from a Cigna Medical Group ("**CMG**") facility or provider even if they do not reside in Arizona (as when traveling). Plan Participants utilizing Cigna participating provider networks in Arizona may access certain specialty and/or ancillary services (such as imaging and urgent care services) through the CMG system. For covered services provided to Participants, CMG is paid at the rates in effect at the time of service (as may be revised from time to time). Representative rates for routinely performed services are attached. A complete copy of the rates is available on request under a mutually agreed nondisclosure agreement ("**NDA**"). If the Plan requires Participants to select a primary care provider ("**PCP**"), Phoenix area Participants who do not select a PCP during open enrollment may be assigned to or otherwise encouraged to consider a CMG PCP. CMG has established collaborative referral relationships	**All Medical Products**

	with specialty and ancillary providers in Cigna's broader participating provider network. CMG may also receive applicable performance-based incentive payments for its participation in programs designed to improve quality, patient safety and affordability.	

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

EFFECTIVE APRIL 1, 2018

(Applicable to Open Access Plus Products)

Department	CPT Code	Description	Rate
All Departments	99213	OFFICE VISIT,EST EXP PROB FOC	$65.80
Adult Medicine	99396	WELL EXAM, EST, 40-64 YEARS	$102.94
Pediatrics	99392	WELL EXAM, EST, 1-4 YEARS	$85.77
Ophthalmology	66984	REMOVE CATARACT, INSERT LENS-Professional Fee only, at a facility	$700.01
Podiatry	11721	DEBRIDEMENT NAIL SIX OR MORE	$39.95
Radiology	71020	CHEST X-RAY, PA & LAT	$30.38
Radiology	G0202 + 77052	SCREENING MAMMOGRAPHY DIGITAL	$141.02
General Surgery	47562	LAPAROSCOPY;CHOLECYSTECTOMY-Professional Fee only, at a facility	$837.79
Optometry	92014	EYE EXAM & TREATMENT	$109.35
ASC (Ambulatory surgical center) / Endoscopy Suite	Grouper 2		$469.00
ASC Endoscopy Suite	Grouper 8		$1,104.00

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

The Urgent Care case rate excluding radiology and laboratory services is $115.

CMG pharmacy rates:

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

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

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

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

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

Appendix A – Pharmacy Benefit Management Services

PHARMACY BENEFIT MANAGEMENT - DEFINITIONS

Definitions

Any capitalized term not defined below shall have the meaning given to such term in the Agreement. Any capitalized term utilized in the Schedule of Financial Charges or Exhibit B shall have the meaning given to such term in the Agreement, including the meanings set forth below.

- "Actuarially Estimated" shall mean that the discount(s) listed in the Schedule of Financial Charges are estimated, but not guaranteed, to result in a particular average discount for Covered Drugs administered by CHLIC under this Agreement. Actuarially estimated discounts are calculated based on evaluation of an expected distribution of drug utilization across CHLIC's aggregate group client book of business. As measured in the aggregate for Employer's Pharmacy Benefit, Employer's average discount results may vary based on the Plan-specific factors such as drug mix utilization.

- "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"), Covered Drug specific, quantity appropriate actual package size (or the manufacturer-packaged quantity closest to the dispensed size), submitted by a Retail Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy 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, including, for example, any change in the markup, methodologies, processes or algorithms underlying the published AWP(s), CHLIC may adjust any or all of the Rebates, charges, rates, discounts, guarantees and/or fees in connection with CHLIC's administration of the Pharmacy Benefit hereunder, including any that are based on AWP, as it reasonably deems necessary to preserve the economic value or benefit of this Agreement to CHLIC as it existed immediately prior to such change. Additionally, and notwithstanding any other provision in this Agreement, CHLIC may replace AWP as its pharmaceutical pricing benchmark with an alternative benchmark and/or may replace Medi-Span, or other such publication, as its source for the AWP or alternative benchmark with a different pricing source, provided that CHLIC adjusts any or all such AWP-based charges or such alternative benchmark-based charges as it reasonably deems necessary to preserve the economic value or benefit of this Agreement to CHLIC as it existed immediately prior to such replacement or immediately prior to the event(s) giving rise to such replacement, as the case may be.

- "Brand Drug" shall mean a pharmaceutical product, including a Covered Drug that is a prescription drug, including over-the-counter drugs dispensed pursuant to a prescription, medicine, agent, substance, device, supply or other therapeutic product that is not a Generic Drug. Except if and where the language expressly states otherwise, a Brand Drug does not include a Specialty Brand Drug for ingredient

cost discount purposes.

- "Business Decision Team" shall mean a committee comprised of voting and non-voting representatives across various Cigna business units such as clinical, medical and business leadership that is duly authorized by Cigna to make decisions regarding coverage treatment of pharmaceutical products based on clinical findings provided by the P&T Committee, including, but not limited to, decisions regarding tier placement and application of utilization management to pharmaceutical products.
- "Cigna Home Delivery Pharmacy" shall mean a duly licensed pharmacy operated by CHLIC or its affiliates, where prescriptions are filled and delivered via the mail service, which may include Tel-Drug of Pennsylvania LLC and Tel-Drug, Inc.
- "Claim", for purposes of this Appendix A, is a claim or request for coverage under the Pharmacy Benefit.
- "Compound Drug shall mean a medication that (a) is comprised of two or more gaseous, solid, semi-solid, or liquid ingredients (other than water or flavoring added to any preparation) that are weighed or measured at a pharmacy and then prepared according to the prescriber's order and the pharmacist's art; (b) contains at least one FDA-approved federal legend drug as an active ingredient; (c) is not otherwise generally available in its compound form; and (d) is not a compound preparation administered by infusion or injection.
- "Covered Drugs" shall mean prescription drugs, including over-the-counter drugs dispensed pursuant to a prescription, biologics, medicines, agents, substances, devices, supplies, and other therapeutic products that are prescribed for Members and are covered under the Pharmacy Benefit and shall include all associated standard services usually and customarily rendered by a pharmacy or provider in the normal course of business, including dispensing, administration, counseling and product consultation.
- "Dispensing Fee" means an amount paid to a pharmacy for providing professional services necessary to dispense a Covered Drug to a Member.
- "FDA" shall mean the U.S. Food and Drug Administration.
- "Formulary" shall mean the list of FDA-approved prescription drugs and supplies developed and managed by CHLIC across its self-funded and insured group book of business and that is selected and adopted by Employer. The drugs and supplies included on the Formulary will be modified by CHLIC from time to time as a result of factors including, but not limited to, economic and clinical factors like clinical appropriateness, manufacturer Rebate arrangements and patent expirations. Any changes CHLIC makes to the Formulary are hereby adopted by Employer.
- "Generic Drug" means a pharmaceutical product, including a Covered Drug, whether identified by its chemical, proprietary, or non-

proprietary name, that is accepted by the FDA as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient(s), and which is identified as such in CHLIC's master drug file using indicators from First Databank, Medi-Span, or other nationally recognized source as used by CHLIC across its book of business on the basis of a proprietary algorithm, a summary of which may be made available for review by Employer or, subject to CHLIC's consent, its auditor upon request in accordance with the terms set forth in this Appendix A. Employer and, as applicable, its auditor shall sign a confidentiality agreement acceptable to CHLIC relating specifically to such summary. The reference to a drug by its chemical name does not necessarily mean that the product is recognized as a generic for adjudication, pricing or copay purposes. Except if and where the language expressly states otherwise, a Generic Drug does not include a Specialty Generic Drug for ingredient cost discount purposes. For pricing purposes, a Generic Drug excludes a Covered Drug that is either marketed under three (3) or fewer Abbreviated New Drug Application pursuant to 21 U.S.C. §355, and its implementing regulations, or cannot be purchased by the pharmaceutical industry at large from more than one (1) pharmaceutical wholesaler.

- "Maximum Allowable Charge" shall mean the maximum unit price for a Covered Drug included on the applicable MAC List as set forth on such MAC List.

- "MAC List" shall mean a then-current list maintained by CHLIC of prescription drugs, devices, supplies and over-the-counter drugs identified as readily available as a Generic Drug or generally equivalent to a Brand Drug (in which case it may also be on a MAC List) and that, in each case, are deemed to require or are otherwise capable of pricing management due to the number of manufacturers, utilization and/or pricing volatility.

- "Pharmacy Benefits" shall mean amounts payable for covered pharmacy benefit services and products under the terms of the Plan; Pharmacy Benefits shall be considered Plan Benefits for purposes of this Agreement.

- "P&T Committee" shall mean a committee comprised of both voting and non-voting Cigna-employed clinicians, Medical Directors and Pharmacy Directors and non-Employees such as Participating Providers that represent a range of clinical specialties. The committee regularly reviews pharmaceutical products, new pharmaceutical products, for safety and efficacy, the findings of which clinical reviews inform coverage status decisions made by the Business Decision Team. The P&T Committee's review may be based on consideration of, without limitation, FDA-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

- "PBM Proprietary Information" shall mean information relating to CHLIC's pharmacy benefit management products and services, including, without limitation, CHLIC's reporting and web-based applications, eligibility and adjudication systems and coding methodologies, system formats and databanks, clinical or formulary management operations or programs, information and agreements relating to Rebates and other financial information, prescription drug evaluation criteria and coverage policies, drug pricing information,

including MAC List and Specialty Drug pricing, paid Claims information integrated into CHLIC's adjudication systems, and pharmaceutical manufacturer, vendor or pharmacy network agreements.

- "Prescription Drug Charge" shall mean the amount that, prior to application of the Plan's cost-share requirement(s), Employer is obligated to pay for a Covered Drug dispensed at a Retail Pharmacy or Cigna Home Delivery Pharmacy, including any applicable Dispensing Fee, service fee, and tax. The Prescription Drug Charge may be expressed as, for example, a discount off of AWP or other benchmark price, or a MAC.

- "Rebate" shall mean the following payments or other consideration paid or payable to CHLIC from manufacturers to the extent arising from or as a result of Covered Drugs dispensed to Members and/or the performance of any pharmacy benefit management services provided under the Agreement.

  (a) Payments, rebates and other consideration paid to CHLIC from any manufacturer arising from or as a result of the inclusion or exclusion on any Formulary of Covered Drugs manufactured, sold, marketed, or distributed by any manufacturer;

  (b) Rebates, discounts, service fees and other consideration paid to CHLIC from any manufacturer arising from or as a result of any arrangements, commitments, programs or activities involving or relating to utilization (e.g., market share, growth, etc.) of certain prescription drugs within their respective therapeutic categories; and

  (c) Rebates, discounts, service fees and other consideration paid to CHLIC from any manufacturer arising from or as a result of any arrangements, commitments, programs or activities involving or relating to services performed by CHLIC where CHLIC is paid or is entitled to fees or other compensation on the basis of the volume or value of prescription drugs or other products that are prescribed or dispensed to CHLIC customers.

  However, "Rebates" shall exclude: (i) pricing adjustments, payments and credits made in the ordinary course by any manufacturer on account of product returns, delivery errors or shipping damage or losses arising from drugs and other products purchased from such manufacturer by or on behalf of CHLIC; (ii) pricing discounts paid or credited by a manufacturer to pharmacies affiliated with CHLIC for prescription drugs and other products purchased from such manufacturer; (iii) any fees or other compensation paid by any manufacturer in consideration of any services, products, activities or programs performed, provided or implemented by CHLIC or any of its affiliates for such manufacturer; (iv) payments, rebates or other compensation paid to CHLIC for or by reason of any administrative or other services provided by CHLIC to or for any manufacturer, in connection with administering, computing, invoicing, allocating and/or collecting amounts otherwise constituting Rebates; and (v) rebates or other amounts paid to CHLIC for prescription drugs that are administered or otherwise provided to Members in providers' offices, home health care settings, or outpatient clinics.

- "Retail Pharmacy" shall mean any licensed retail pharmacy with which CHLIC has contracted directly or indirectly with a third party, to provide Covered Drugs to Members, and is not a mail order pharmacy. A mail order pharmacy is a pharmacy that primarily fills and delivers pharmaceutical products via the mail service. The term "Retail", when immediately preceding the term "Brand Drug Claim", "Generic Drug Claim", "Specialty Drug Claim", "Specialty Brand Drug Claim", or "Specialty Generic Drug Claim" means that the resulting term (e.g., "Retail Brand Drug Claim") refers to such claim as dispensed by a Retail Pharmacy.

- "Specialty Drug" shall mean a pharmaceutical product, including a Covered Drug, considered by CHLIC to be a Specialty Drug based on consideration of the following factors: (i) whether the pharmaceutical product is prescribed and used for the treatment of a complex, chronic or rare condition; (ii) whether the pharmaceutical product has a high acquisition cost; and, (iii) whether the pharmaceutical product is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Drug may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a pharmaceutical product will be considered a Specialty Drug. The term "Specialty," when immediately preceding the terms "Generic Drug" or "Brand Drug", means that the resulting term (e.g. "Specialty Generic Drug") refers to a Generic Drug or Brand Drug that is considered a Specialty Drug, respectively.

- "Specialty Pharmacy" shall mean a duly licensed pharmacy designated by or operated by CHLIC or its affiliates that primarily dispenses Specialty Drugs or provides services related thereto; provided, however, that when the Cigna Home Delivery Pharmacy dispenses a Specialty Drug, it shall be considered a Specialty Pharmacy hereunder.

- "U&C Charge" shall mean the price the applicable Retail Pharmacy would charge a regular cash-paying customer for a Covered Drug (and any services related to the dispensing thereof) on the day on which the Covered Drug is dispensed.

PHARMACY BENEFIT MANAGEMENT - SERVICES TO BE PROVIDED

1. Retail Pharmacy Network.

(a) General. CHLIC shall maintain a Retail Pharmacy network. Retail Pharmacies included in the network shall provide Covered Drugs to which the Retail Pharmacies have access to Members during their normal business hours in all applicable locations. A list of the Retail Pharmacies included in the network, as updated from time to time, shall be made available to Members online. CHLIC maintains multiple networks and/or sub-networks and may periodically consolidate networks and/or migrate clients, including Employer, between networks and sub-networks. CHLIC shall require each Retail Pharmacy included in the network to meet its requirements for participation in the Retail Pharmacy network, which include, but are not limited to, satisfaction of licensing and insurance requirements.

(b) Retail Pharmacy Audits and Overpayments. CHLIC shall perform desktop and on-site audits of each Retail Pharmacy to ensure that each Retail Pharmacy is complying with the terms of its contract with CHLIC. In the event that CHLIC discovers that an overpayment has been made to a Retail Pharmacy, CHLIC shall take reasonable steps to recover the overpayment pursuant to the terms of this Agreement.

(c) Independent Contractors. The Retail Pharmacies are independent contractors, and CHLIC does not exert direction or control over the pharmacists at Retail Pharmacies in filling prescriptions or performing other pharmaceutical services.

(d) Collection of Cost Sharing. CHLIC shall require Retail Pharmacies to collect all applicable Plan cost-shares from Members.

2. Cigna Home Delivery Pharmacy.

(a) General. Members may submit new or refill prescription orders for fulfillment through Cigna Home Delivery Pharmacy or such other mail service pharmacy that CHLIC in its sole discretion may select from time to time. Such orders may be placed via mail, telephone, or electronic means. Subject to Applicable Law, Employer shall permit CHLIC to communicate with Members regarding availability and use of the Cigna Home Delivery Pharmacy and potential cost savings associated therewith. In addition, CHLIC may provide supporting services with respect to the Cigna Home Delivery Pharmacy. Cigna Home Delivery Pharmacy shall deliver all drugs to Members in accordance with its standard procedures. For the purposes of clarity, CHLIC does not exert direction or control over the pharmacists at Cigna Home Delivery Pharmacy in filling prescriptions or performing other pharmaceutical services.

(b) Cost Sharing. Members are responsible for payment of the applicable cost sharing to Cigna Home Delivery Pharmacy for each prescription or prescription refill. Employer acknowledges that Cigna Home Delivery Pharmacy may suspend services to a Member who is in default of any cost-sharing obligations, in accordance with Cigna Home Delivery Pharmacy's standard credit policy. If payment of such cost-sharing has not been received from the Member within one hundred twenty (120) days of dispensing of the product, the Plan will be billed for the outstanding amount following the one hundred twenty (120) day collection period.

(c) Affiliation with CHLIC. Tel-Drug of Pennsylvania LLC and Tel-Drug, Inc. are licensed pharmacy affiliates of CHLIC that fill and deliver Covered Drugs via the mail service.

3. Claims Processing.

(a) General. CHLIC shall perform claims processing services for Covered Drugs dispensed by Retail Pharmacies or Cigna Home Delivery Pharmacy. In-network Claims shall be submitted via paper or electronically. Members using out-of-network covered services are required to submit a paper claim form. A separate charge shall apply for submission of any paper claim form, whether in-network or out-of-network. CHLIC does not provide coordination of benefits (COB) services for Claims for drugs dispensed, and electronically processed, at a pharmacy; Claims will be processed without consideration of a Member's coverage under another plan.

(b) Drug Utilization Review. CHLIC shall perform a concurrent Drug Utilization Review ("DUR") analysis of each prescription submitted for processing, which may include: (1) prescribed dosage within a safe range; (2) drug-to-drug interaction; (3) drug-to-allergy interaction; (4) age-to-drug interaction; (5) duplicate therapy; (6) quantity limitations; and (7) days' supply.CHLIC's DUR processes shall not override or substitute for the prescriber's, the pharmacist's or other health care provider's professional judgment.

4. **Utilization Management Program**. CHLIC shall, in accordance with Section 2 of the Agreement, administer the Pharmacy Benefit utilization management program(s) identified in this Agreement. Employer acknowledges that CHLIC's coverage policies and claims administration procedures, which are utilized across CHLIC's self-funded and insured book-of-business to adjudicate claims and administer appeals, may change periodically. As an example of the coverage criteria that may apply to a pharmaceutical product, a Member may have to try one or more preferred pharmaceutical products, or demonstrate why trying the preferred pharmaceutical product(s) would be clinically inappropriate, in order to obtain coverage under the Plan for a given pharmaceutical product Employer further authorizes CHLIC to allow coverage for a use that would be otherwise excluded in the event of co-morbidities, complications and other factors not expressly addressed by the coverage policies utilized by CHLIC in reviewing Claims for coverage. CHLIC may rely wholly upon information about the Member and the prescriber's diagnosis of the Member's condition. CHLIC shall not substitute its judgment for the judgment of the prescribing physician, nor shall it determine medical necessity or make other medical determinations other than for coverage purposes.

5. **Rebate Management**. CHLIC shall pay Employer amounts equal to the Rebate amounts specified in the Schedule of Financial Charges.

6. **Drug-Related Services**.

(a) Specialty Drugs. CHLIC shall process Claims regarding Specialty Drugs subject to the following provisions:

(1) The Specialty Pharmacy shall fill prescriptions for Specialty Drugs based on the professional judgment of the dispensing pharmacist, accepted pharmacy practices and product guidelines.

(2) A list of Specialty Drugs available via the Specialty Pharmacy and pricing with respect thereto shall be made available as in effect on the Effective Date, are set forth in Appendix B. After the Effective Date, Employer may request that CHLIC provide it with an updated list of Specialty Drugs available via the Specialty Pharmacy and pricing with respect thereto.

(3) To the extent acting in the capacity as a mail order pharmacy, the Specialty Pharmacy shall ship Specialty Drugs to Members in accordance with its standard procedures.

(4) Members are responsible for payment of the applicable cost sharing to the Specialty Pharmacy for each prescription or prescription refill. Employer acknowledges that the Specialty Pharmacy may suspend services to a Member who is in default of any cost-sharing obligations, in accordance with the Specialty Pharmacy's standard credit policy. If payment has not been received from the Member within one hundred twenty (120) days of dispensing, the Plan will be billed following the one hundred twenty (120) day collection period.

(5) For the purposes of clarity, CHLIC does not exert direction or control over the pharmacists at the Specialty Pharmacy in filling prescriptions or performing other pharmaceutical services.

(b) Compound Drugs. CHLIC shall process prescribed Compound Drugs to the extent covered under the Plan. CHLIC shall treat as Covered Drugs only those components of a Compound Drug that would otherwise be treated as Covered Drugs were they not part of a Compound Drug.

7. Member Communications and Services.

(a) Member Communication. CHLIC shall provide to Members an ID card and instructions to access Member materials online, including the Formulary, the Retail Pharmacy directory, Cigna Home Delivery Pharmacy information, and an out-of-network Claim reimbursement form.

(b) Rx Savings Messenger. CHLIC may send personalized mailings to Members regarding the Generic Drugs and preferred Brand Drugs and savings available from Cigna Home Delivery Pharmacy.

(c) Call Center. CHLIC shall maintain toll-free customer service lines twenty-four (24) hours per day, seven (7) days per week for the purpose of responding to inquiries from Members regarding Retail Pharmacy, Cigna Home Delivery Pharmacy or Claims issues.

8. Formulary Management; Clinical Programs; Other Services.

CHLIC shall provide Formulary management services, which shall include implementing Formulary placement decisions and determinations to apply utilization management requirements made by CHLIC's Business Decision Team. The Business Decision Team makes Formulary determinations based on consideration of clinical and economic factors. Clinical factors may include, but are not limited to, the CHLIC P&T Committee's evaluation of the place in therapy, relative safety or relative efficacy of the drug, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the drug's acquisition cost including, but not limited to, assessments on the cost effectiveness of the drug and available Rebates. Employer acknowledges that the Formulary, utilization management requirements, and coverage policies used by CHLIC to perform coverage reviews, including any changes made thereto, are adopted by Employer. When considering a drug for Formulary placement or other coverage conditions, CHLIC's Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its relevant book-of-business. CHLIC shall also provide the clinical, safety and/or trend programs, or other programs and services selected by Employer as indicated on the Schedule of Financial Charges or otherwise agreed upon by Employer and CHLIC, some of which may require payment of additional fees.

PHARMACY BENEFIT MANAGEMENT - PROGRAM OPERATIONS

1. **Implementation of Agreement**.

   (a) Project Plan. Employer and CHLIC shall develop an agreed upon implementation project plan with respect to the Agreement prior to the Effective Date or prior to the implementation with respect to any new Pharmacy Benefit under this Agreement following the Effective Date.

   (b) Initial Data and Commencement of Pharmacy Benefit Management Services. Prior to the Effective Date, Employer shall provide CHLIC with all data and/or documentation necessary for CHLIC to provide the services specified in this Agreement. Such data and/or documentation shall include, but is not necessarily limited to, claims history and Member prior authorization history. Assuming all data specified in the preceding sentence is received sufficiently in advance of the Effective Date, CHLIC shall commence providing services under this Agreement as of the Effective Date.

2. **Timely Provision of Data by Employer**. Employer acknowledges that CHLIC shall not be held responsible for, and shall be released from, fulfilling any obligation or performing any service under this Agreement if Employer or its designee does not provide accurate information in a timely manner.

3. **Reporting**. CHLIC shall make available to Employer CHLIC's standard reporting applications, subject to Applicable Law and Exhibit D, including, without limitation, HIPAA and state privacy laws.

4. **Claims Data**.

(a) Retention. CHLIC shall retain data with respect to Claims for at least seven (7) years from the date the prescription is filled. Following the close of such retention period, CHLIC shall retain and dispose of such Claims data pursuant to its then-current standard policies and procedures, Applicable Law and the Business Associate Agreement described in the Agreement.

(b) Disclosure to Vendor. Upon Employer's written request and subject to execution of a non-disclosure agreement acceptable to CHLIC, CHLIC shall provide prescription Claims data in its standard format to a vendor contracted with Employer and otherwise acceptable to CHLIC solely for the purposes of such vendor's support of Plan administration functions. Employer agrees that its vendors may not utilize Claims data for any other purpose, including, without limitation, developing products and services, analyzing the Claims data against market benchmarks or CHLIC competitors or adding to a normative database (even if de-identified and/or blinded as to Member and PBM/carrier) for the Employer's or vendor's commercial use. Employer shall be responsible for any use or disclosure of Claims data, or any services provided, by the vendor. Notwithstanding the foregoing, all audits of any pricing guarantees, Rebate-sharing obligations or Claims processing accuracy shall be conducted in accordance with the terms in this Agreement specifically relating to such audits.

(c) De-Identified Data. During and after the term of this Agreement, CHLIC may use Claims, drug, and medical data that has been de-identified in accordance with HIPAA for research, provider evaluation, database maintenance, and other commercial purposes.

This provision shall survive termination or expiration of the Agreement.

5. **Claims Processing Audits**. Employer may, in accordance with the requirements set forth in Section 6 of the Agreement and at no additional charge while this Agreement is in effect, audit CHLIC's payment of Plan Benefits subject to the conditions set forth in Section 6 of the Agreement.

6. **Rebate Audits**. Employer may, to the extent specified below, in accordance with the following requirements, and at no additional charge while this Agreement is in effect, audit CHLIC's Rebate payments subject to the following conditions:

(a) Employer shall designate with CHLIC's consent, such consent not to be unreasonably withheld, an independent, third party auditor to conduct the audit (the "Auditor").

(b) The Auditor may audit records directly related to CHLIC's performance of its obligations hereunder regarding Rebates once in each 12-month period upon the following conditions: (1) Employer shall provide at least 45 days written notice to CHLIC; (2) the Auditor (including each auditor conducting the audit) shall be agreeable to Employer and CHLIC; (3) a mutually agreed upon

nondisclosure/nonuse contract shall be executed by Employer, the Auditor and CHLIC; (4) the records to be audited shall be no more than two years old as of the date of the audit; (5) the scope of records to be audited shall be as mutually agreed upon by the Auditor and CHLIC as those which are necessary to determine compliance with the Rebate-sharing obligations under this Agreement; (6) the audit shall be conducted at a mutually acceptable time during regular business hours at CHLIC's office where such records are located; (7) records shall not be removed or photocopied without CHLIC's express written consent; (8) the Auditor shall provide its audit report to CHLIC and Employer at the same time; and (9) the Auditor may disclose the aggregate amount of Rebates due Employer but no other details of CHLIC's manufacturer contracts of which the Auditor is apprised, if any.

This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT - FUNDING AND PAYMENT OF CLAIMS; CHARGES

1. **Funding and Payment of Claims**. With respect to Pharmacy Benefits, (1) CHLIC may withdraw funds from the Bank Account for the purposes specified in Section 3 of the Agreement five times per month, and (2) any recovered overpayments shall be credited to Employer via a line item on its invoice, less the fee set forth on the Schedule of Financial Charges.

2. **Retroactive Member Changes and Terminations**. Notwithstanding anything in the Agreement to the contrary,Employer shall remain responsible for all charges and Bank Account Payments incurred or charged through the date CHLIC processed Employer's notice of a retroactive change or termination of a Member's enrollment in the Plan. Notwithstanding anything to the contrary in Section 4.c. of the Agreement, with respect to Pharmacy Benefits, CHLIC generally will implement eligibility updates received from Employer that adhere to CHLIC's standard electronic format as soon as reasonably practicable following receipt of such updates.

PHARMACY BENEFIT MANAGEMENT - FIDUCIARY ACKNOWLEDGMENTS

CHLIC offers pharmacy benefit management services for consideration by Employer and other entities. The general parameters of such services and the supporting systems have been developed by CHLIC as part of CHLIC's administration of its general business as a pharmacy benefit manager for entities that sponsor group health plans. The Parties have negotiated the terms of this Agreement in an arm's-length fashion. Except to the extent CHLIC conducts the final level of internal appeal as set forth in Section 2.c of the Agreement, the Parties assert that neither Party intends that CHLIC shall be a fiduciary with respect to Pharmacy Benefits for either ERISA (if applicable) or state law purposes, and neither Party shall name CHLIC as a "plan fiduciary" with respect to its management of Pharmacy Benefits. Employer acknowledges and agrees that CHLIC (i) does not have discretionary authority or control respecting management of the Pharmacy Benefits, and (ii) does not exercise any authority or control respecting management or disposition of the assets relating to Pharmacy Benefits or of Employer. Rather, Employer retains all such authority and control. The Parties agree that, upon reasonable notice, CHLIC shall have the right to terminate its Pharmacy Benefit services under this Agreement to any Plan and/or Members located in a state that requires a pharmacy benefit manager to be a fiduciary to Employer, the Plan or a Member.

This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT - FINANCIAL ARRANGEMENTS

1. **General**. CHLIC contracts on its own account with Retail Pharmacies to dispense covered pharmaceutical products to Employer's Members, and not on behalf of, or for the benefit of, Employer or the Plan; accordingly, any discounts or other remuneration CHLIC earns under an arrangement with a Retail Pharmacy are obtained for, and inure to, the sole and exclusive benefit of CHLIC, and not the Employer or the Plan. Amounts paid to the Retail Pharmacy for Brand Drug, Generic Drug, or Specialty Drug Claims may or may not be equal to the amount charged to Employer and/or Member. If the amount paid by Employer and/or Member does not equal the amount paid by CHLIC to a particular pharmacy, CHLIC will absorb or retain such difference. CHLIC contracts with pharmaceutical manufacturers for Rebates and other remuneration on its own behalf and for its own benefit, and not on behalf of Employer or the Plan. Accordingly, CHLIC retains all right, title and interest to any and all actual Rebates and other remuneration received from manufacturers. CHLIC will pay Employer amounts equal to all or some portion of the Rebate amounts allocated to Employer, if any, and as specified on the Schedule of Financial Charges, from CHLIC's general assets (neither Employer, its Members, nor Employer's Plan retains any beneficial or proprietary interest in CHLIC's general assets). Rebate amounts received vary based on factors including, without limitation, Employer-specific utilization, the volume of utilization as well as Formulary position applicable to the drug or supplies, and adherence to various formulary management controls, benefit design requirements, Claims volume, and in certain instances also may vary based on the product market share. Employer acknowledges and agrees that neither it, its Members nor its Plan will have a right to interest on, or the time value of, any Claim payments charged by CHLIC to Employer or any Rebate payments received by CHLIC during the collection period of moneys payable under this section, and that CHLIC shall retain any such remuneration.

2. **Affiliates**. Cigna Home Delivery Pharmacy and any other licensed pharmacy affiliate of CHLIC may maintain product purchase discount arrangements and/or fee-for-service arrangements with pharmaceutical manufacturers and wholesale distributors in its capacity as a mail service and/or specialty pharmacy. Cigna Home Delivery Pharmacy or any other licensed pharmacy affiliate of CHLIC may contract for these arrangements on its own account in support of its pharmacy operations, and not on behalf of, or for the benefit of, Employer of the Plan. Accordingly, Cigna Home Delivery Pharmacy and any other licensed pharmacy affiliate of CHLIC retains the sole and exclusive benefit of any difference between its acquisition cost for a pharmaceutical product and the amount charged to Employer under this Agreement. Further these arrangements relate to services provided outside of this Agreement and other pharmacy benefit management arrangements and may be entered into without regard to whether a specific drug is on one of the formularies that CHLIC offers to entities that sponsor group health plans. Discounts and fee-for-service payments received by Cigna Home Delivery Pharmacy or any other licensed pharmacy affiliate of CHLIC are not part of the pharmacy benefit management formulary rebates or associated administrative fees or charges paid to CHLIC in connection with CHLIC's pharmacy benefit management formulary rebate programs.

This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT - OBLIGATIONS UPON TERMINATION

Upon notice of termination of this Agreement, the following provisions shall apply with respect to Pharmacy Benefits:

a) Employer shall notify Members at least thirty (30) days prior to the termination of the Agreement becoming effective of any transition to a successor pharmacy benefit manager.

b) If mutually agreed upon by CHLIC and Employer, CHLIC shall provide services following termination of the Agreement at CHLIC's then-prevailing rate. Such services, if any, shall be determined by mutual agreement of CHLIC and Employer in advance of the termination of the Agreement becoming effective.

c) Upon request by Employer and subject to execution of a nondisclosure agreement acceptable to CHLIC, CHLIC shall transition Claims files and/or history to the pharmacy benefit manager or other third party specified by Employer and otherwise acceptable to CHLIC. Any disclosure of Claims files and/or history shall be limited to the information the successor pharmacy benefit manager or other third party needs to implement or administer Employer's pharmacy benefits. CHLIC shall not be required to directly or indirectly release, and Employer shall not release, PBM Proprietary Information to any such third party.

d) Upon termination of the Agreement for any reason, the Parties shall handle Confidential Information, PBM Proprietary Information and Protected Health Information (as defined in the Business Associate Agreement attached as Exhibit D) pursuant to the terms of the Agreement.

e) In the event that CHLIC terminates the Agreement pursuant to Section 1.v of the Agreement, CHLIC shall have no further obligation following the date of such termination to pay Employer any Rebates, or any other amount that may otherwise be payable by CHLIC to Employer.

This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT - CONFIDENTIALITY

1. **General**. Employer acknowledges and agrees that CHLIC's PBM Proprietary Information constitutes competitively sensitive trade secrets, and that its misuse or mis-disclosure could result in material financial and legal loss or liability to CHLIC, its affiliates and their respective subcontractors. CHLIC shall not be required to disclose PBM Proprietary Information to Employer except to the extent necessary for Employer to exercise any audit rights expressly provided hereunder or perform other Plan administration functions. If CHLIC discloses PBM Proprietary Information to Employer, or, if CHLIC consents, to the Employer's vendor or designee, CHLIC may require Employer, or its vendor or designee, to execute a non-disclosure agreement specifically relating to the requested PBM Proprietary Information. Employer agrees that it and its vendors may not utilize PBM Proprietary Information for any purpose other than performing

Plan administration functions, including, without limitation, developing products and services, de-identifying, blinding or analyzing the PBM Proprietary Information against market benchmarks or CHLIC competitors or adding to a normative database for the Employer's, or vendor's or designee's, commercial use. For the purposes of clarity, information shall not cease to qualify as PBM Proprietary Information if Employer or its vendor or designee de-identifies and/or blinds the PBM Proprietary Information such that the information cannot be traced or identified to a Member or CHLIC, its affiliates or their respective subcontractors. Employer shall be solely responsible for any disclosure of PBM Proprietary Information by CHLIC to Employer or its vendor or designee, or any subsequent use or disclosure by Employer or its vendor or designee, or services provided by the same. Notwithstanding anything herein to the contrary, in no event will CHLIC be required to disclose to Employer, or its vendor or designee, information related to, or including, its pharmacy network agreements, vendor agreements or pharmaceutical manufacturer agreements.

2. **Compelled Disclosures**. If at any time Employer, or its vendor or designee, is required by law, court order or other valid legal process to disclose any Confidential Information, it will promptly notify CHLIC prior to any such compelled disclosure and, upon request, cooperate with CHLIC in seeking a protective order or other available relief to contest or limit the scope of such compelled disclosure.

3. **Return or Destruction of Information**. At any time upon CHLIC's request or upon expiration or termination of this Appendix A or the Agreement, whichever occurs first, Employer will, at CHLIC's option, promptly deliver, or, as the case may be, compel its vendor or designee to deliver, to CHLIC all PBM Proprietary Information or other Confidential Information (or such portion thereof as requested) and not retain any copies in whole or in part of such PBM Proprietary Information or other Confidential Information, or securely destroy or dispose, or, as the case may be, compel its vendor or designee to destroy or dispose, of those portions of documents and other materials in any form, including electronic form, prepared by or received by the Employer or its vendor or designee, that contain or reflect such PBM Proprietary Information or other Confidential Information. Employer, or its vendor or designee, shall certify such return and destruction, as the case may be, to CHLIC.

Appendix B - Cigna Home Delivery Pharmacy Specialty Drug List

THIS SPECIALTY DRUG LIST IS CONFIDENTIAL, PROPRIETARY INFORMATION OF CHLIC. IT IS PROVIDED SOLELY FOR EMPLOYER'S PLAN ADMINISTRATION PURPOSES. RE-DISCLOSURE IS STRICTLY PROHIBITED EXCEPT AS OTHERWISE PROVIDED BY APPLICABLE LAW. CHLIC RESERVES ALL LEGAL RIGHTS AND REMEDIES TO ENFORCE THESE PROHIBITIONS ON USE AND DISCLOSURE.

The Specialty Drug List shall be provided separately to Employer, and is hereby incorporated into the Agreement by reference, inclusive of any changes made subsequent to CHLIC's initial issuance of the Specialty Drug List to Employer to the pharmaceutical products included on the Specialty Drug List or the discounts pertaining to such pharmaceutical products. Upon Employer's request on or after the Effective Date, CHLIC shall provide to Employer an updated Specialty Drug List.

Currently Marketed Specialty Drugs on this Specialty Drug List. The discounts in this Specialty Drug List are the discounts that will be adjudicated in CHLIC's claim processing system for the drug indicated when dispensed by Cigna Home Delivery Pharmacy, subject to all of the following.

- Any or all of the discounts in this Specialty Drug List may be adjusted by CHLIC to the extent reasonably necessary to preserve the economic value of this Agreement as it existed immediately prior to the occurrence of any of the following events: a major change in market conditions affecting the pharmaceutical or pharmacy benefit management market, a drug shortage in the market, an issue involving the safety of the drug supply, or similar market situation.

- The discounts in this Specialty Drug List are based on the terms and design of the Pharmacy Benefit that Employer has adopted and disclosed to CHLIC. Accordingly, if Employer fails to disclose to CHLIC, for example, that it uses or intends to use a consumer-driven health plan, a major cost-sharing program, or a utilization management program promoting generic or OTC drugs over brand drugs, CHLIC may adjust the discounts as it reasonably deems necessary to preserve the economic value or benefit of this Agreement as CHLIC anticipated based on the terms and design of the Pharmacy Benefit previously disclosed to CHLIC and prior to CHLIC's discovery of the Pharmacy Benefit design feature that materially impacts CHLIC's discounts in this Specialty Drug List.

- The discounts in this Specialty Drug List shall not apply to Compound Drug claims, Claims that process at U&C, and direct member reimbursement (DMR) Claims.

- Any or all of the discounts in this Specialty Drug List may be adjusted by CHLIC to the extent reasonably necessary to preserve the economic value of this Agreement as it existed immediately prior to the occurrence of any of the following events: (a) there are any significant changes in the composition of CHLIC's pharmacy network or in CHLIC's pharmacy network contract compensation rates, or the structure of the pharmacy stores/chains/vendors that are contracted with CHLIC, including but not limited to disruption in the retail pharmacy delivery model, or bankruptcy of a chain pharmacy; or (b) there is a change in government laws or regulations which has a significant impact on pharmacy claim costs; or (c) any material manufacturer-rebate contracts with or for the benefit of CHLIC are terminated or modified in whole or in part; or (d) there is any legal action or Law that materially affects or could materially affect the manner in which CHLIC's rebate program is administered or an existing Law is interpreted so as to materially affect or potentially have a material effect on CHLIC's administration of the Pharmacy Benefit; or (e) there is a material

change in the Plan or the Plan's Pharmacy Benefit that is initiated by Employer which impacts CHLIC's costs.

New-to-Market Specialty Products. Specialty Drug Claims that are for new-to-market drugs will have a minimum market-introduction guaranteed discount of 11.45% off the drug's AWP.

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')

Attached to and made part of Group Policy No. 3338881

It is hereby agreed that said policy is amended as follows:

- Page CSL-Policy(07-17) headed COVERAGE INFORMATION is deleted and the attached Pages headed COVERAGE INFORMATION is substituted therefore.

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')
Schedule of Insurance

Coverage Information

Policyholder:	City of Santa Fe
Policy Number:	3338881
Effective Date:	July 01, 2019
Issue Date:	May 30, 2019
Next Renewal Date:	July 01, 2020
State or other Jurisdiction of Issue:	New Mexico

Notices

For the purpose of any notices required under this policy, such notices should be sent to the addresses shown below:

Cigna Health and Life Insurance Company
900 Cottage Grove Road, Hartford, CT 06152
Attn: Stop Loss Unit

City of Santa Fe
200 Lincoln Ave
Santa Fe, NM 87501
Attn: Vicki Gage / City of Santa Fe
vlgage@santafenm.gov
505-995-6595

Notice to Policyholder - *ADDITIONAL PROGRAMS* – Cigna may, from time to time, offer or arrange for various entities to offer discounts, benefits, services or other consideration to the Policyholder's employees for the purpose of promoting their general health and well-being. For details about these programs, contact Cigna. Any such consideration shall be provided by Cigna in connection with its administrative services agreement for the administration of the Policyholder's self-insured Plan and shall not be considered a benefit of this policy nor create any relationship between Cigna and the Policyholder's employees with respect to this policy.

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')
Individual Stop Loss Coverage

Policy Year: July 01, 2019 to June 30, 2020

Covered Expenses: Claims that are Incurred between July 01, 2014 and June 30, 2020 and that Become Due between July 01, 2019 and June 30, 2020

Monthly Premium Rates:
For each covered employee $85.50

Individual Stop Loss Benefit Percentage Payable: 100%

Individual Stop Loss Limit: $250,000.00

The following Covered Persons have been identified as High Risk Individuals and shall be subject to the Individual Stop Loss Limit as specified below:

High Risk Individuals None

Benefit Plans Covered by Individual Stop Loss Coverage:

Claim Administrator	Product
Cigna	HRA Open Access Plus Plan
Cigna	Mental Health/Substance Use Disorders
Cigna	Open Access Plus Core Plan
Cigna	Open Access Plus Premium Plan
Cigna	Pharmacy Expense

Cigna's Maximum Liability per individual: Will be the individual maximum, if any, as set forth in the Benefit Plan less the Individual Stop Loss Limit

Additional exclusions from Individual Stop Loss coverage under this policy:

- Funds contributed by the company or an employee as part of a Health Reimbursement Account, Health Savings Account or Flexible Spending Account.
- Expenses resulting from fixed, per person, per period charges (fixed charges), if any, i.e., contractually determined periodic payments to certain providers based on the number of Plan participants entitled to receive services from the provider, in return for which, such providers furnish certain agreed-upon services to Plan participants.
- All Retirees

CIGNA HEALTH AND LIFE INSURANCE COMPANY
(Herein called 'Cigna')

Aggregate Stop Loss Coverage

Policy Year: July 01, 2019 to June 30, 2020

Covered Expenses: Claims that are Incurred between July 01, 2014 and June 30, 2020 and that Become Due between July 01, 2019 and June 30, 2020

For purposes of Aggregate Stop Loss, amounts attributable to claim base state surcharges, covered lives assessment and cost containment fees, as applicable, shall not be considered to be an excluded expenses of the Policyholder or Claim Administrator and as such shall be considered Covered Expenses.

Monthly Premium Rates:
For each covered employee $4.93

Aggregate Stop Loss Benefit Percentage Payable: 100%

Aggregate Individual Stop Loss Limit: $250,000.00

Benefit Plans Covered by Aggregate Stop Loss Coverage:

Claim Administrator	Product
Cigna	HRA Open Access Plus Plan
Cigna	Mental Health/Substance Use Disorders
Cigna	Open Access Plus Core Plan
Cigna	Open Access Plus Premium Plan
Cigna	Pharmacy Expense

Cigna's Maximum Liability for the Aggregate Stop Loss coverage: Unlimited for the Policy Year

Corridor Factor: 125%

Minimum Attachment Point: $25,411,111.00

Minimum Attachment Percentage: 100%

Minimum Attachment Lagged Month: Two Months prior to the Policy Year's first Policy Month

Lagged Month: Two Months Prior

This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT - FINANCIAL ARRANGEMENTS

1. General. CHLIC contracts on its own account with Retail Pharmacies to dispense covered pharmaceutical products to Employer's Members, and not on behalf of, or for the benefit of, Employer or the Plan; accordingly, any discounts or other remuneration CHLIC earns under an arrangement with a Retail Pharmacy are obtained for, and inure to, the sole and exclusive benefit of CHLIC, and not the Employer or the Plan. Amounts paid to the Retail Pharmacy for Brand Drug, Generic Drug, or Specialty Drug Claims may or may not be equal to the amount charged to Employer and/or Member. If the amount paid by Employer and/or Member does not equal the amount paid by CHLIC to a particular pharmacy, CHLIC will absorb or retain such difference. CHLIC contracts with pharmaceutical manufacturers for Rebates and other remuneration on its own behalf and for its own benefit, and not on behalf of Employer or the Plan. Accordingly, CHLIC retains all right, title and interest to any and all actual Rebates and other remuneration received from manufacturers. CHLIC will pay Employer amounts equal to all or some portion of the Rebate amounts allocated to Employer, if any, and as specified on the Schedule of Financial Charges, from CHLIC's general assets (neither Employer, its Members, nor Employer's Plan retains any beneficial or proprietary interest in CHLIC's general assets). Rebate amounts received vary based on factors including, without limitation, Employer-specific utilization, the volume of utilization as well as Formulary position applicable to the drug or supplies, and adherence to various formulary management controls, benefit design requirements, Claims volume, and in certain instances also may vary based on the product market share. Employer acknowledges and agrees that neither it, its Members nor its Plan will have a right to interest on, or the time value of, any Claim payments charged by CHLIC to Employer or any Rebate payments received by CHLIC during the collection period of moneys payable under this section, and that CHLIC shall retain any such remuneration.

2. Affiliates. Cigna Home Delivery Pharmacy and any other licensed pharmacy affiliate of CHLIC may maintain product purchase discount arrangements and/or fee-for-service arrangements with pharmaceutical manufacturers and wholesale distributors in its capacity as a mail service and/or specialty pharmacy. Cigna Home Delivery Pharmacy or any other licensed pharmacy affiliate of CHLIC may contract for these arrangements on its own account in support of its pharmacy operations, and not on behalf of, or for the benefit of, Employer of the Plan. Accordingly, Cigna Home Delivery Pharmacy and any other licensed pharmacy affiliate of CHLIC retains the sole and exclusive benefit of any difference between its acquisition cost for a pharmaceutical product and the amount charged to Employer under this Agreement. Further these arrangements relate to services provided outside of this Agreement and other pharmacy benefit management arrangements and may be entered into without regard to whether a specific drug is on one of the formularies that CHLIC offers to entities that sponsor group health plans. Discounts and fee-for-service payments received by Cigna Home Delivery Pharmacy or any other licensed pharmacy affiliate of CHLIC are not part of the pharmacy benefit management formulary rebates or associated administrative fees or charges paid to CHLIC in connection with CHLIC's pharmacy benefit management formulary rebate programs.

This provision shall survive termination or expiration of the Agreement.

Victoria A. Sirica
Operations Senior Manager
Cigna

April 14, 2020

Routing B2CAU
900 Cottage Grove Road
Hartford, CT 06152
Telephone 860.226.2785
Facsimile 860.730.3944
Victoria.sirica@cigna.com

Bernadette Salazar
Director, Human Resources
City of Santa Fe
200 Lincoln Ave
Santa Fe, NM 87501

RE: Administrative Services Only Account No. 3338881

Dear Bernadette Salazar:

This letter will serve as an amendment to the Administrative Services Only Agreement between Cigna Health and Life Insurance Company ("**CHLIC**") and City of Santa Fe ("**Employer**"), effective July 1, 2015, (the "Agreement") and as amended on July 1, 2016, July 1, 2017 and July 1, 2019 and supplemented by the disclosure letter effective July 1, 2018.

Effective as of July 1, 2020, 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.v. of the Administrative Services Only Agreement is hereby amended in its entirety as follows:

v. Notwithstanding the foregoing, all provisions in this Agreement reasonably related to CHLIC's administration of the Plan's Pharmacy Benefit (as such term is defined in Appendix A) (the "Pharmacy Benefit Provisions"), shall continue in effect for no less than thirty six (36) months commencing on July 1, 2020, except that, if any of the following dates occurs, the Pharmacy Benefit Provisions set forth in the Schedule of Financial Charges and Appendix A will cease being in effect as of such date:

   a. The effective date of any Applicable Law or governmental action which prohibits performance of the activities in connection with the Pharmacy Benefit required by this Agreement;

   b. The date upon which Employer fails to fund the Bank Account as required by this Agreement for claims under the Pharmacy Benefit provided CHLIC notifies Employer of its election to terminate the Pharmacy Benefit Provisions;

   c. The date upon which Employer fails to pay CHLIC any charges in connection with the Pharmacy Benefit identified in this Agreement when due, provided CHLIC notifies Employer of its election to terminate the Pharmacy Benefit Provisions; or

   d. The date that is sixty (60) days after notice by either Employer or CHLIC ("non-defaulting party") of the material breach by the other (the "defaulting party") of a material obligation of the defaulting party related to the Pharmacy Benefit (other than failure to fund the Bank Account or failure to pay any charges when due pursuant to Sections 1.v.b and 1.v.c above) that is not cured to the reasonable satisfaction of the non-defaulting party within a reasonable time following the initial notice of breach.

"Cigna" is a registered service mark and the "Tree of Life" logo is a service mark of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Cigna Health and Life Insurance Company, Cigna Health and Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

During such thirty six (36) month period (or shorter period, as applicable under (a), (b), (c) or (d) above), CHLIC will continue to be the exclusive provider of Pharmacy Benefit administration services for the Plan's Pharmacy Benefit.

In the event that Employer purports to terminate such arrangement or enters into an agreement with another pharmacy benefit manager ("PBM") or other third party to provide any or all pharmacy benefit management services for Employer's benefit plan prior to the end of such thirty six (36) month period, then, within thirty (30) days of CHLIC's written request, Employer shall pay CHLIC the amount of $1.50 per the average monthly number of Members who were enrolled in the Plan's Pharmacy Benefit from the beginning of the thirty six (36) month period to the effective date of such purported termination or other agreement multiplied by the number of months remaining until the end of the thirty six (36) month period. However, if Employer terminates its CHLIC medical coverage under this Agreement, no such fee shall apply.

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

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

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

a. Employer Liability for Plan Benefits. Employer is solely responsible for all Plan Benefits including any Plan Benefits paid as a result of any legal action. Except as provided in Section 7.c, Employer is responsible for reimbursing CHLIC, its directors, officers and employees for any reasonable expense incurred (including reasonable attorneys' fees) by them in the defense of any action or proceeding involving a claim for Plan Benefits. CHLIC shall reasonably cooperate with Employer, in its defense of such actions.

   If Employer directs CHLIC in writing to pay Extra-Contractual Benefits, Employer is responsible for funding the payment and such payments shall not be considered in determining reimbursements or payments under stop loss insurance provided by CHLIC or CHLIC affiliate or in determining any CHLIC or CHLIC affiliate risk-sharing or performance guarantee reimbursements. Employer shall reimburse CHLIC for any liability or expenses (including reasonable attorneys' fees) CHLIC may incur in connection with making such payments.

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

Section 9. Modification of Agreement

This Agreement constitutes the entire contract between the Parties regarding the subject matter herein. Except, as otherwise provided herein, the provisions of this Agreement shall control in the event of a conflict with the terms of any other agreements. Except for changes to the charges or other financial terms, including any terms or conditions related thereto, identified in this Agreement, no modification or amendment hereto shall be valid unless in writing and agreed to by an authorized person of each of the Parties. This Agreement may not be modified by any shrink-wrap, click-wrap, browse-wrap, click-through, web-site based, online or use agreements ("Click-Wrap") that purport to be accepted or deemed accepted by download or online acknowledgment. The charges identified in this Agreement may be revised in accordance with Section 8 by CHLIC providing written notice to Employer and Employer indicating its acceptance of the modification either by paying the revised charges or failing to object to such revised charges in writing to CHLIC within fifteen (15) business days of receipt of such notice from CHLIC. The revised charges will be effective on the date indicated in CHLIC's written notice to Employer unless otherwise agreed to by CHLIC and Employer.

Section 12.b of the Administrative Services Only Agreement is hereby amended in its entirety as follows:

b. In the event that a Controversy has not been resolved within thirty-five (35) calendar days of the request of Executive Review under Section 12.a, above, either Party may initiate mediation by providing written notice to the other Party, which shall be conducted in Hartford, Connecticut, in accordance with the American Arbitration Association Commercial Mediation Rules ("**Mediation**") using American Arbitration Association mediators. Each Party shall assume its own costs and attorneys' fees, and the compensation and expenses of the mediator and any administrative fees or costs associated with the mediation proceeding shall be borne equally by the Parties. The Parties shall not, however, be required to mediate the Controversy.

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

The terms of the Administrative Services Only Agreement identified above, as mentioned herein, will be effective as of July 1, 2020. Please indicate your agreement to the amendment by signing the enclosed copy of this letter where indicated and returning it to me. Alternatively, this amendment shall become effective on the effective date indicated unless Employer notifies CHLIC either electronically or in writing (at the address indicated above) within sixty (60) days of the date of this letter that it does not accept all the terms of this amendment notwithstanding any provision to the contrary in the Administrative Services Only Agreement. In that case, CHLIC shall cooperate to negotiate mutually agreeable terms with Employer. Once agreement with respect to the terms of the amendment is reached, the amendment will apply retroactively to the effective date.

Sincerely,

Victoria A. Sirica
Its Operations Senior Manager
Duly Authorized
Cigna Health and Life Insurance Company

Accepted by: **City of Santa Fe**

By: _____

Name: _____

Title: _____

Executed this ____ day of _____, in the year _____

Schedule of Financial Charges

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

	MEDICAL/DENTAL ADMINISTRATION CHARGES	
Product	**Description**	**Charge**
Medical	HRA Open Access Plus (OAP) with Care Management Preferred (All Plans)	**$46.40/employee/month**
Medical	Open Access Plus (OAP) with Care Management Preferred (All Plans)	**$41.26/employee/month**
Dental	Dental Preferred Provider Organization (DPPO)	**$3.67/employee/month**
	MEDICAL/DENTAL NETWORK ACCESS FEE, UTILIZATION MANAGEMENT FEE AND OPTIONAL PROGRAM FEE	
Product	**Description**	**Charge**
Medical	HRA OAP Access Fee (All Plans)	**$24.14/employee/month Included in Medical Administration Charge**
Medical	OAP Access Fee (All Plans)	**$24.14/employee/month Included in Medical Administration Charge**
Dental	DPPO Access Fee	**$0.86/employee/month Included in Dental Administration Charge**

	MULTI-YEAR CHARGE/FEE GUARANTEES	
	The maximum increase for the Medical and Dental Administration Charge(s) and Network Access Fee(s) for the 2021 Plan Year will be 2.00% over the 2020 Plan Year charges/fees. The maximum increase for the Medical and Dental Administration Charge(s) and Network Access Fee(s) for the 2022 Plan Year will be 2.00% over the 2021 Plan Year charges/fees. The maximum increase for the Medical and Dental Administration Charge(s) and Network Access Fee(s) for the 2023 Plan Year will be 2.00% over the 2022 Plan Year charges/fees. The above fee guarantees are not applicable to Pharmacy Administration Fee. The above charges/fees are guaranteed for the time periods identified above, provided, however, that CHLIC may revise the above charges/fees pursuant to Section 8 of this Agreement.	
	CIGNA CHOICE FUND AND OTHER CONSUMER DIRECTED ACCOUNT ADMINISTRATION SERVICES AND CHARGES	
	Product	**Charge**
	Cigna Choice Fund Health Reimbursement Account (HRA) Administration	**For HRA OAP Products: $5.14/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. • Education and referral coaching on program topics with referral to appropriate internal and external resources available. • Access to educational materials and web based Member tools and resources. • Identification of gaps in care and outreach to Member to provide coaching for those identified with gaps for high cholesterol, high blood pressure, and additional coaching on other gaps in care will also occur. • Support of Participants identified through predictive modeling with certain preference sensitive care conditions by supplying impartial evidence based medical information, to empower Participants to understand the potential benefits/ disadvantages of a specific course of action and make more informed care decisions. • Answering health and medical related questions. • Counseling Participants on prevention and the benefits of compliance with prescribed medications and treatments.	**For HRA OAP Only: Included in Medical Access Fee**
	Dependent Care Flexible Spending Account (DFSA) Administration	**For DFSA Products: Included at No Additional Cost**
	Health Care Flexible Spending Account (FSA) Administration	**For FSA Products: $5.79/employee/month**

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

CIGNA PHARMACY BENEFIT MANAGEMENT SERVICES CHARGES AND RELATED PROVISIONS
PHARMACY ADMINISTRATION FEE
Cigna Pharmacy Product Administration Fee, only if applicable, is separate from the Medical Administration Charge shown above, but included on same billing line as the Medical Administration Charge for billing purposes only.
CHARGES FOR COVERED DRUGS
Drugs Dispensed by Cigna Home Delivery Pharmacy: CHLIC will charge Employer for Covered Drugs dispensed to Members by Cigna Home Delivery Pharmacy based on the following charges, subject to the "PBM Pricing – Additional Provisions" section:
Brand Drug Claims: AWP minus an Actuarially Estimated average discount of 23.50%. **Generic Drug Claims:** The Generic Drug's charge on a CHLIC MAC List which generates an Actuarially Estimated average discount on Generic Drugs across those CHLIC clients in the aggregate using such MAC List of AWP minus 85.00%. **Specialty Drug Claims:** The Specialty Drug's charge discounted as shown in the Cigna Home Delivery Pharmacy Specialty Drug List, attached as Appendix B hereto. **Dispensing Fees for Both Brand Drug Claims and Generic Drug Claims:** An average Dispensing Fee of no more than $0.00.
Covered Drugs Dispensed by Retail Pharmacies in 30-day* supplies: CHLIC will charge Employer for 30-day supplies of Covered Drugs dispensed by a Retail Pharmacy based on the following charges, subject to the "PBM Pricing – Additional Provisions" section: ***A 30-day supply means any Covered Drug dispensed by a Retail Pharmacy in an amount less than an 83-day supply.**
Brand Drug Claims: The lesser of (i) AWP minus an Actuarially Estimated average discount of 19.20%; or (ii) the Retail Pharmacy's U&C Charge. **Generic Drug Claims:** The lesser of: (i) the Generic Drug's charge on a CHLIC MAC List which generates an Actuarially Estimated average discount on Generic Drugs across those CHLIC clients in the aggregate using such MAC List of AWP minus 82.25%; or (ii) the Retail Pharmacy's U&C Charge. **Specialty Generic Drug Claims:** The Specialty Generic Drug's charge discounted as shown in the Specialty Drug List, attached as Appendix B hereto. **Dispensing Fees for Both Brand Drug Claims and Generic Drug Claims:** An Actuarially Estimated average Dispensing Fee of no more than $0.90, except in the case of Claims adjudicated at the U&C Charge, for which no separate Dispensing Fee is charged.

Covered Drugs Dispensed by Retail Pharmacies: CHLIC will charge Employer for Claims for Covered Drugs dispensed by Retail Pharmacies regardless of days' supply based on the following charges, subject to the provisions in the section titled "PBM Pricing - Additional Provisions":

Specialty Brand Drug Claims: The lesser of (i) AWP minus an Actuarially Estimated annual average aggregate discount of 12.50%; or (ii) the Retail Pharmacy's U&C Charge.

Covered Drugs Dispensed by Retail Pharmacies in 90-day supplies:** CHLIC will charge Employer for 90-day supplies of Covered Drugs dispensed by a Retail Pharmacy based on the following charges, subject to the "PBM Pricing – Additional Provisions" section:

****A 90-day supply means any Covered Drug dispensed by a Retail Pharmacy in an amount equal to or greater than an 83-day supply.**

Brand Drug Claims: The lesser of (i) AWP minus an Actuarially Estimated average discount of 23.50%; or (ii) the Retail Pharmacy's U&C Charge.

Generic Drug Claims: The lesser of: (i) the Generic Drug's charge on a CHLIC MAC List that generates an Actuarially Estimated average discount on Generic Drugs across those CHLIC clients in the aggregate using such MAC List of AWP minus 85.00%; or (ii) the Retail Pharmacy's U&C Charge.

Specialty Generic Drug Claims: The Specialty Generic Drug's charge discounted as shown in the Specialty Drug List, attached as Appendix B hereto.

Dispensing Fees for Both Brand Drug Claims and Generic Drug Claims: An average Dispensing Fee of no more than $0.00, except in the case of Claims adjudicated at the U&C Charge, for which no separate Dispensing Fee is charged.

PBM PRICING – ADDITIONAL PROVISIONS

- The amount paid by CHLIC to the Retail Pharmacy for Claims for Covered Drugs may or may not be equal to the amount charged to Employer and/or Member, and CHLIC will absorb or retain any difference.
- For a specific Claim for a Covered Drug dispensed by a Retail Pharmacy or Cigna Home Delivery Pharmacy, and after application of any Plan cost-share requirements, CHLIC shall charge the Employer the lowest of the following amounts:

  (1) The Prescription Drug Charge; or

  (2) The pharmacy's submitted U&C Charge, if any.

- For a specific Claim for a Covered Drug dispensed by a Retail Pharmacy or Cigna Home Delivery Pharmacy, CHLIC shall charge the Member in accordance with the terms of the Pharmacy Benefit. For example, for a Covered Drug subject to a fixed dollar copayment requirement, CHLIC shall charge the Member the lowest of the following amounts:

  (1) The fixed dollar copayment for the Covered Drug, if any;

  (2) The Prescription Drug Charge; and

  (3) The pharmacy's submitted U&C Charge, if any.

- Unless specifically noted herein, the discounts to Employer for Covered Drugs set forth in this Agreement are not guaranteed to result in an average aggregate discount off the aggregate AWP of all such Covered Drugs.

- Any pricing guarantees, including any ingredient cost discount or Dispensing Fee guarantee, set forth in this Agreement shall be rendered null and void in the event Employer terminates CHLIC's administration of the Pharmacy Benefit prior to completion of the then-current Plan Year. CHLIC's fees, Rebates (if any), discounts or guarantees (if any) are, among other conditions communicated in this Agreement or otherwise in writing to Employer, contingent on, and assume, adoption by Employer of a specific Formulary, Retail Pharmacy network, and Plan design features (e.g. cost-share structure, utilization/cost management programs).

- Notwithstanding any other provision of this Agreement, CHLIC may, effective upon written notice to Employer, adjust any or all of the fees, Rebates (if any), discounts or guarantees (if any) in this Agreement to the extent reasonably necessary to preserve the economic value of this Agreement to CHLIC as it existed immediately prior to any of the following events or changes: (a) there are any significant changes in the composition of the CHLIC pharmacy network utilized by Employer hereunder or in such pharmacy network's contract compensation rates, or the structure of the pharmacy stores/chains/vendors that are contracted with CHLIC, including but not limited to disruption in the retail pharmacy delivery model, or bankruptcy of a chain pharmacy; or (b) there is a change in government laws or regulations which has a significant impact on pharmacy claim costs; or (c) any material manufacturer-rebate contracts with, or for the benefit of, CHLIC are terminated or modified in whole or in part; or (d) there is any legal action or law that materially affects, or could materially affect the manner in which CHLIC's rebate program is administered or an existing law is interpreted so as to materially affect or potentially have a material effect, on CHLIC's administration of the Plan; (e) a major change in market conditions affecting the pharmaceutical or pharmacy benefit management market, a drug shortage in the market, an issue involving the safety of the drug supply, an unexpected introduction of a new drug (e.g. authorized generic), or similar market event occurs; (f) the Pharmacy Benefit enrollment decreases by equal to or greater than 15% from the enrollment on which CHLIC's financial offer is based; or (g) there is material change in the Plan that is initiated by Employer (and which CHLIC agrees to administer) such as a change in Formulary selection or network, or Employer fails to disclose a material feature of the Plan or the Plan's Pharmacy Benefit.

DRUG MANUFACTURER-PAYMENT SHARING

Subject to the caveats below, CHLIC will remit to Employer the following portion of Rebates that CHLIC collects with respect to utilization of Covered Drugs under the Plan's Pharmacy Benefit:

For All Products:

$100.00 per Retail Pharmacy Brand Drug Claim dispensed in a 30-day* supply, $235.00 per Retail Pharmacy Brand Drug Claim dispensed in a 90-day** supply and $450.00 per Cigna Home Delivery Pharmacy Brand Drug Claim.

Caveats:

(1) Upon termination of this Agreement, CHLIC may use Rebates otherwise payable to Employer to offset payable Bank Account Payments or other payable fees or changes identified in this Agreement. CHLIC may also use Rebates otherwise payable to Employer to offset any stop-loss reimbursement payments payable by CHLIC or its affiliate to Employer under a stop-loss policy issued to Employer.

(2) Should Employer terminate this Agreement before completion of the then-current Plan Year, no Rebates shall be due with respect to that Plan Year, and any Rebate minimum or fixed dollar guarantees shall be null and void, as payments of Rebates is conditioned on CHLIC exclusively administering the Pharmacy Benefits for the entire Plan Year.

(3) For percentage-based sharing arrangements, payout amount may differ slightly from the stated percentage when payout occurs before manufacturers' final reconciliations and payments are made to CHLIC. For the purposes of clarity, CHLIC shall reconcile its performance with respect to any Rebate payment guarantees, including, without limitation, any minimum or fixed dollar guarantees, in the aggregate. Moreover, any amount directly or indirectly earned by CHLIC from a manufacturer or other third party that is allocated to reduce and/or wholly or partially satisfy a Member's cost-sharing obligation for a Covered Drug shall not be considered a "Rebate" for the purposes of Rebate payments to Employer but may be included when reconciling CHLIC's performance against any Rebate minimum guarantee set forth in this Agreement.

(4) CHLIC or its agent contracts with drug manufacturers on CHLIC's own behalf, and not as agent of the Employer or the Plan.

(5) The Rebate payment commitments, including any minimum or fixed dollar guarantees, if any, set forth in this Schedule of Financial Charges are, among any other conditions communicated in this Agreement or otherwise in writing to Employer, contingent on the availability of Rebates to CHLIC and Employer's Pharmacy Benefit applying a 90-day supply limit for Specialty Drugs. For example, in the event that Employer has adopted, or adopts, a 30-day supply limit for Specialty Drugs, CHLIC shall revise the stated Rebate minimum

or fixed dollar guarantees, if any, to the extent necessary to reflect CHLIC's revised estimate of Rebates it may collect on Specialty Drugs utilized under the Pharmacy Benefit.

Timing of Rebate Pay-Out: Remittance will be provided within ninety (90) days after the close of each applicable calendar year for the portion of such calendar year that coincides with the Plan Year.

REBATE PAYMENT EXCLUSIONS

Any rebate or other drug manufacturer payment obligations set forth in this Schedule of Financial Charges exclude the following types of claims and/or products:

- Direct Member Reimbursement Claims.
- Vaccines.
- Compound Drugs.
- Claim reversals.
- Products identified as prescriptions covered under the federal 340B drug pricing program. Employer shall be solely responsible for ensuring that any pharmacy affiliated with or operated by Employer or its affiliate, such as an in-house pharmacy, systematically identifies 340B prescriptions on Claim transactions administered by CHLIC. If such pharmacy fails to systematically identify 340B prescriptions on Claim transactions submitted to CHLIC, then CHLIC may withhold all Rebates, or modify any minimum or fixed dollar Rebate guarantee, otherwise attributable to utilization at such pharmacy.
- Run-Out Claims.

PHARMACY VACCINE PROGRAM
Notwithstanding anything to the contrary in this Agreement or otherwise, the following terms and conditions shall apply to the administration of vaccines by CHLIC under the Cigna Pharmacy Program. Vaccine Claims will adjudicate at the lower of the U&C Charge or the amounts shown in the Vaccine Pricing Schedule below. For Vaccine Claims, the U&C Charge shall be the retail price charged by an in-network participating retail pharmacy for the particular vaccine, including administration and dispensing fees, in a cash transaction on the date the vaccine is dispensed as reported to CHLIC by the in-network participating pharmacy. "Vaccine claim" means a claim for a Covered Drug which is a vaccine. "Pass Through Pricing" means the actual ingredient cost and dispensing fee amount paid by CHLIC for the Vaccine claim when the Vaccine claim is adjudicated by an in-network participating pharmacy, as set forth in the specific in-network participating pharmacy remittances related to the Vaccine claim. Notwithstanding anything to the contrary in this Agreement or otherwise, all vaccine claims shall be excluded from the calculation, measurement, and payment of any and all financial guarantees, including but not limited to rebate guarantees, ingredient cost guarantees, and dispensing fee guarantees set forth in this Agreement.

Vaccine Pricing Schedule

	Retail Pharmacy INFLUENZA	**Retail Pharmacy ALL OTHER VACCINES**	**Member Submitted Vaccine Claims**
Vaccine Administration Fee	Pass-Through Pricing (Capped at $15 per in-network vaccine claim)	Pass-Through Pricing (capped at $20 per in-network vaccine claim)	Submitted amount
Ingredient Cost	Retail Pharmacy Ingredient Cost as set forth in this Agreement	Retail Pharmacy Ingredient Cost as set forth in this Agreement	Submitted amount
Dispensing Fee	Retail Pharmacy Dispensing Fee as set forth in this Agreement	Retail Pharmacy Dispensing Fee as set forth in this Agreement	Submitted amount

CIGNA HOME DELIVERY PHARMACY DISCLOSURE		
	Product	**Charge**
Cigna Home Delivery Pharmacy (a CHLIC affiliated company(ies))	Specialty drugs dispensed by Cigna Home Delivery Pharmacy and administered under the Plan's medical benefit. "Cigna Home Delivery Pharmacy" means a duly licensed pharmacy operated by CHLIC or its affiliates, where prescriptions are filled and delivered via the mail service, which may include, for example, Accredo Health Group, Inc., Tel-Drug of Pennsylvania LLC and Tel-Drug, Inc. Cigna Home Delivery Pharmacy may maintain product purchase discount arrangements and/or fee-for-service arrangements with pharmaceutical manufacturers and wholesale distributors. Cigna Home Delivery Pharmacy contract for these arrangements on its own account in support of its pharmacy operations. These arrangements relate to services provided outside of this Agreement and other pharmacy benefit management arrangements and may be entered into without regard to whether a specific drug is on one of the formularies that CHLIC offers to entities like Employer that sponsor group health plans. Discounts and fee-for-service payments received by Cigna Home Delivery Pharmacy are not part of the administrative fees or other charges paid to CHLIC in connection with CHLIC's services hereunder. This provision shall survive termination or expiration of the Agreement.	**The drug's charge under a national specialty drug discount schedule that generates a 12.5% annual average aggregate discount off AWP across specialty drug claims dispensed at Cigna Home Delivery Pharmacy to CHLIC's self-funded and insured group-client book of business.**
FEES FOR PROCESSING RUN-OUT CLAIMS		
HRA OAP, OAP and DPPO	Run-Out Period of twelve (12) months	**No Additional Cost**
Pharmacy	Run-Out Period of three (3) months for all pharmacy claims	**No Additional Cost**

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

CHLIC MEDICAL COST CONTAINMENT FEES

CHLIC administers the programs listed below to contain costs with respect to charges for health care service/supplies that are covered by the Plan (the "**Cost-Containment Programs**"). In administering these Cost-Containment Programs, CHLIC may contract with vendors to perform various Cost-Containment Program related services. Vendor fees generally range from 7-11% of gross savings. Specific vendor fees are available upon request subject to execution of a mutually agreed upon non-disclosure agreement to protect the proprietary vendor fee information from unauthorized use/disclosure. CHLIC's charge for administering a Cost-Containment Program is the percentage indicated below of either: (1) the "gross savings" (i.e., the difference between the charge the provider would have made and the charge the provider actually made as a result of the Cost-Containment Program). Any applicable vendor fee is included in CHLIC's charge and paid to the vendor by CHLIC; or (2) the "net savings" (i.e., the gross savings less the applicable vendor fee). With respect to only the "recovery," any applicable vendor fee is included in CHLIC's charge and paid to the vendor by CHLIC; or (3) the "recovery" (i.e., the amount recovered as a result of the Cost-Containment Program). Any applicable vendor fee is included in CHLIC's charge and paid to the vendor by CHLIC.

For charges for covered services received from a non-Participating Provider (including emergency/urgent care services that are covered at the in-network benefit level), CHLIC may apply discounts available under agreements with third parties or through negotiation of the non-Participating Provider's charges whether on a claim-by-claim basis or in advance of services being rendered. These programs are identified below as the Network Savings Program Supplemental Network, and Medical Bill Review (pre-payment). CHLIC charges the percentage shown for administering these programs. Applying these discounts may result in higher payments than if the maximum reimbursable charge is applied. Whereas application of the maximum reimbursable charge may result in the patient being balance billed for the entire unreimbursed amount, applying these discounts avoids balance billing and substantially reduces the patient's out-of pocket cost.

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

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

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

a. the amount of provider's billed charge not exceeding the greater of a CHLIC determined percentage of the Medicare allowable amount (the 80th percentile of the reasonable and customary charge if there is no Medicare allowable charge) or the amount required by state or federal, law (in the case of emergency room services) for charges subject to CHLIC's benefit enhancement policy (patient may be balance billed by the provider if the provider's charge exceeds such amount), or

b. the provider's billed charge.

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

1.	Network Savings Program	**29% of net savings**
2.	Supplemental Network	**29% of net savings**
3.	Medical Bill Review – (Pre-payment Cost Containment for Non-contracted claims):	
	Inpatient Hospital Bill Review	
	• Line Item Analysis	**Lesser of 5% of hospital bill or the gross savings achieved**

	• Professional Fee Negotiation	**29% of net savings**
	Outpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
	Physician/Professional Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
4.	Medical Bill Review – (Pre or Post-payment Cost Containment for Non-contracted and Contracted claims):	
	• Bill Audit	**29% of the gross savings/recovery achieved plus hospital fees or expenses passed through**
	Diagnosis Related Grouping (DRG) Validation/Audits and Recovery. An overpayment audit and recovery program in which CHLIC or its vendors review paid claim data to identify overpayments based on inaccurate DRG coding.	**29% of recovery plus any fees or expenses passed through by the hospital or regulatory agency**
	Medical Implant Device Audits	**29% of recovery**
5.	COB Vendor Recoveries [Exclusive of pharmacy programs where claims are adjudicated at time prescription is received.]	**29% of recovery**
6.	Secondary Vendor Recovery Program	**29% of recovery**
7.	Provider Credit Balance Recovery Program	**29% of recovery**
8.	High Cost Specialty Pharmaceutical Audits (this service is only provided with respect to Medical coverage)	**29% of recovery**
9.	Class Action Recoveries	**35% of recovery**
10.	Eligibility Overpayment Recovery Vendor Services. Identification and recovery of funds in situations where the overpayment is due to the late receipt of Member termination information. (This service is only provided with respect to Medical coverage).	**29% of recovery**

CHLIC PHARMACY COST CONTAINMENT FEES		
CHLIC administers the following programs to contain costs with respect to charges for health care service/supplies that are covered by the Plan. In administering these programs, CHLIC contracts with vendors to perform program related services. CHLIC's charge for administering these programs is the percentage (indicated below) of the "recovery" (i.e. the amount recovered) as applicable.		
1.	Pharmacy Vendor Recoveries. CHLIC performs periodic audits of contracted pharmacies in order to determine the accuracy of payments to the pharmacy(ies). CHLIC's recovery vendor collects and remits to CHLIC all overpayments to pharmacy(ies), and CHLIC remits to Employer's Bank Account the balance collected from the recovery vendor, less the recovery fee set forth herein.	**30% of recovery**
2.	Class Action Recoveries. CHLIC identifies, monitors and may (but is not required to) participate, on behalf of Employer, in class action lawsuits or similar legal proceedings against pharmaceutical manufacturers, including, without limitation, lawsuits alleging legal or equitable claims like fraud, anti-trust violations, or unfair trade practices by a manufacturer. As part of this authority, CHLIC may participate in a settlement, exclude Employer from a settlement and/or otherwise represent Employer's interests outside the settlement. CHLIC collects and retains as a recovery fee set forth herein of any recovery (net of attorneys' fees) attributable to Employer's Plan.	**35% of recovery**

CHLIC DENTAL COST CONTAINMENT FEES		
Dental Cost Containment	CHLIC administers the following program to contain costs with respect to charges for dental services that are covered by the Plan. Applies to 2nd tier of participating DPPO network providers and includes: • Access to an additional network of DPPO dentists who provide care at a discounted rate. Lower out-of-pocket expenses for Members and additional claim savings for Employer when receiving covered services from these DPPO dentists. • CHLIC retains the percentage identified herein of Employer and/or Member gross savings for access and to cover the 2nd tier network administrative cost. • CHLIC calculates the percentage identified herein as fees charged on a pay-as-you save basis. If there is no savings, there is no fee charged to Employer. Gross savings are calculated by taking what the dental professional would have charged if not participating in the network minus the dentist's contracted fee. The dental cost containment fee is charged to Employer via the appropriate Electronic Funds Transfer (EFT) cycle as a percent of the savings assessed weekly against the Bank Account and would appear on Bank Account activity report(s) as Vendor Fee Reimbursement.	**For DPPO Products: 25% of gross savings**
CARE MANAGEMENT/COST CONTAINMENT PROGRAM FEES		
	CHLIC arranges for third parties to provide care management services to: (i) contain the cost of specified health care services/items overall with respect to all plans insured and/or administered by CHLIC, and/or (ii) improve adherence to evidence based guidelines designed to promote patient safety and efficient patient care.	**Specific vendor fees and care management program services are available upon request.**
	In addition to such third parties, CHLIC has arranged for an affiliate, eviCore, to provide the following care management/cost-containment programs	
	• Pre-certification of coverage of radiation therapy services.	**$842.79 per episode of care (EOC)**

	• Pre-certification of coverage of oncology services.	**$581.00 per episode of care (EOC)**
	• Pre-certification of coverage of musculoskeletal therapy services *(If Employer has elected Basic Standard Medical Management (see Administration Charges section above) this program and charge is not applicable to that membership)*	**$0.34 PMPM**
	• Pre-certification of coverage of diagnostic cardiology services *(If Employer has elected Basic Standard Medical Management (see Administration Charges section above) this program and charge is not applicable to that membership)*	**$0.19 PMPM**
	CHLIC may revise charges/fees by giving Employer at least sixty (60) days' prior written notice.	
EXTERNAL REVIEW AND CONSULTATIVE REVIEW FEES		
	When a Member elects an External Review (as that term is defined in the Patient Protection and Affordable Care Act (PPACA)) of a benefit determination by an independent third party, the cost of a specific third party review is dependent on the nature and complexity of the issue on appeal. Third party review charges will be commensurate with the level of expertise necessary and the time required to complete the review.	**$500-$1,500 Review**
STRATEGIC ALLIANCES		
	CHLIC contracts directly or indirectly with other managed care entities and third party network vendors for access to their provider networks and discounts. These third parties charge either a network access fee, which is included in CHLIC's monthly charges, or a percentage of the savings realized on a claim by claim basis as a result of the application of their discounts. Charges based on percentage of savings may be paid from the Bank Account. Additional details regarding specific charges will be provided upon request.	**All Medical Products**

OTHER VENDORS AND HEALTH CARE SERVICES PROVIDERS		
	The fixed per person per period and/or fee-for-service charges that CHLIC has directly or indirectly negotiated with Participating Providers for in-network health care services and/or supplies will be paid as claims for Plan Benefits 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. The fixed per person per period and/or fee-for-service charges that CHLIC has directly or indirectly negotiated with various vendors that arrange for the provision of in-network health care services and/or supplies through their contracted networks of providers may be paid as claims for Plan Benefits and used in calculating any applicable Member cost-sharing. Additional details regarding charges and the identity of the parties arranging for the provision of in-network health care services and/or supplies will be made available upon request.	**All Products**
NOTICE REGARDING PAYMENTS FROM THIRD PARTIES		
	CHLIC contracts with pharmaceutical manufacturers or other third parties for Rebates, Manufacturer Administrative Fees, and other remuneration on its own behalf and for its own benefit, and not on behalf of Employer or the Plan. Accordingly, unless otherwise specified in this Schedule of Financial Charges, CHLIC retains all right, title and interest to any and all actual Rebates, Manufacturer Administrative Fees, and other remuneration received from manufacturers or other third parties; neither Employer, its Members, nor Employer's Plan retains any beneficial or proprietary interest in any such remuneration, which shall be considered part of the general assets of CHLIC. As an example of the remuneration other than Rebates or Manufacturer Administrative Fees that CHLIC may earn, CHLIC may also directly or indirectly earn from pharmaceutical manufacturers remuneration in connection with value payments and/or services that CHLIC provides to Employer ("Value-Based Payments"). Notwithstanding anything in this Agreement to the contrary, any Value-Based Payments earned by CHLIC are separate and apart from any Rebates or Manufacturer Administrative Fees that CHLIC directly or indirectly earns from pharmaceutical manufacturers, and CHLIC may retain any Value-Based Payments it earns. As examples of the value payments and/or services that CHLIC may provide to Employer in connection with Value-Based Payments that CHLIC may earn, CHLIC may provide care management or related services to Employer and/or remit to Employer monetary credits if Members	**All Pharmacy Products**

	discontinue therapy on certain pharmaceutical products. Information regarding any services, and/or monetary credits or other financial value, for which Employer may be eligible with respect to specific pharmaceutical products or therapeutic classes/conditions, including the products for which monetary credits or other financial value may be available to Employer, the amount of that value, and other payment terms, is available upon request. Any value payments and/or services provided by CHLIC to Employer are subject to change or termination by CHLIC as the value program(s), if any, offered by CHLIC change(s) or terminate(s). Information on the projected aggregate amount of such Rebates with respect to the Plan Pharmacy Benefit will be provided upon request. This provision shall survive termination or expiration of the Agreement.	
	CHLIC may directly or indirectly receive and retain payments under contracts with pharmaceutical manufacturers or third parties with respect to Members' utilization of the manufacturer's products covered under the Employer's Plan medical benefit. These payments may include rebates, service fees (e.g. administrative fees), or other remuneration. CHLIC directly or indirectly contracts with pharmaceutical manufacturers or other third parties or any remuneration on its own behalf and for its own benefit, and not on behalf of Employer or the Plan. Accordingly, CHLIC retains all right, title and interest to any and all such remuneration received from manufacturer; neither Employer, its Members, nor Employer's Plan retains any beneficial or proprietary interest in any such remuneration, which shall be considered part of the general assets of CHLIC. This provision shall survive termination or expiration of the Agreement.	**All Medical Products**

	From time to time, CHLIC, directly or through its affiliates, arranges with third parties (e.g., service vendors, provider network managers) to provide various services (e.g., cost-containment services or health care services) in connection with the Plan. CHLIC and its affiliates may receive payments from such third parties to help defray CHLIC's expenses associated with its implementation and/or ongoing administration of these arrangements or as a reimbursement for services or network access provided to such parties by CHLIC. CHLIC may also receive compensation from third-party vendors that Employer may retain based upon a referral from CHLIC or that Members may utilize following an introduction facilitated by CHLIC or an affiliate. CHLIC may also receive: • network administration fees from some providers participating in its provider network, • credits from banks on balances in accounts utilized to administer claims, • non-material incidental compensation/benefits from other source as a result of administering the Plan.	**All Products**
	COMPLIANCE ASSISTANCE	
	CHLIC shall provide the following services to assist Employer in meeting its compliance obligations under section 2715 of the Public Health Service Act as added by the Patient Protection and Affordable Care Act and applicable regulations with respect to the provision of the Summary of Benefits and Coverage ("**SBC**"), translation notice and glossary. Applicable to all medical plans including HRA and FSA which are considered "group health plans" subject to the SBC requirements.	
1.	Preparation of SBC, translation notice. CHLIC will not be responsible for any changes that Employer makes to the SBC.	**No charge**
2.	Provide SBC, translation notices prepared by CHLIC to Employer electronically as well as any updates or material modifications.	**No charge**
3.	Include in SBC a summary of benefits administered by carve-out vendor if Employer or carve-out vendor provides CHLIC with necessary carve-out benefit information at least twelve (12) weeks prior to the date the SBCs are to be delivered to Employer.	**$500 for each benefit option under the Plan for which carve-out vendor benefits are included in SBC**

ADDITIONAL SERVICES		
Service	**Description**	**Charge**
Pharmacy Utilization Management Program	**Essential Package** - a utilization management program under which some pharmaceutical products are subject to one or several coverage limitations, including prior authorization, step therapy and/or quantity limits. Under a prior authorization requirement, the requested drug is generally reviewed for clinical appropriateness based on the intended use in therapy. Under a step therapy requirement, the Member generally must try one or more preferred products, or demonstrate why trying the preferred product(s) would be clinically inappropriate, in order to obtain coverage for the requested drug.	**For All Products: Included in Pharmacy Administration Fee**
Clinical Program	A targeted condition medication therapy management program in which CHLIC provides support for Members using specialty medications for certain chronic conditions and that are obtained or administered at retail pharmacies or outpatient, office or home health care settings. As part of the program, Members are counseled on their condition, medication side effects, and importance of adherence. For the sake of clarity, if a specialty pharmacy affiliate of CHLIC provides therapy management for specialty medications the pharmacy dispenses to Members, then it does so in its capacity as a specialty pharmacy and not on behalf of CHLIC; CHLIC does not exert direction or control over the pharmacists at any specialty pharmacy affiliate.	**For HRA OAP** **and OAP Products: Included at No Additional Cost**

Your Health First	A proactive health education and improvement program for Members with a chronic condition. The program involves services that span across the Member's health needs. Behavioral coaching principles and evidence based medicine guidelines are utilized to optimize self-management skills and foster sustained health improvements. The program targets a chronic population at high risk for near term and future high cost medical expenses. Members are identified as having a chronic condition through a variety of sources which may include: claims data, referrals, and self-identification. A variety of resources is provided to those with a chronic condition, including access to online tools, personalized support, and targeted materials. The program includes the following components for those with a chronic condition: • Chronic condition-specific coaching • Pre- and post-discharge calls • Lifestyle management coaching: stress, weight management and tobacco cessation • Treatment decision support and coaching In order to continuously assess the effectiveness of the program and/or test new ideas to further engage Members around their health, a small sample of Members may be placed in a comparison group which for a defined period of time receives alternative services or is suppressed from receiving proactive outreach, such as engagement letters and/or calls. This could affect a few Members targeted for outreach during this limited time period.	**For HRA OAP** **and OAP Products: Included in Medical Access Fee**
Claim Litigation	Claim Litigation Services	**$3,500.00 Flat Annual Amount Included in Medical Administration Charge**
Claim and Appeals	CHLIC will administer an optional second level of claim appeals	**$0.94/employee/year Included in Medical Administration Charge**

One Guide	The One Guide advocacy solution utilizes a multimodal approach to support Member Participants and help them successfully navigate the health care system. Member Participants are serviced by personal guides that include frontline service staff, as well as clinicians and non-clinician support staff from our medical, behavioral and pharmacy programs. In addition to connecting with personal guides via telephone, Member Participants can also interact with personal guides via the click-to-chat feature on myCigna.com (web and app), enabling Member Participants to engage with CHLIC and One Guide in the way in which they prefer. One Guide helps simplify and strengthen the connection between Member Participants, their benefit plan, and their overall health and well-being. Through personalized and relevant messaging, One Guide proactively engages Member Participants with clear ways to save money, stay healthy, and improve health outcomes that lead to a healthy lifestyle. One Guide offers: • education on health plan features, account balances and ways to maximize benefits and earn available incentives • guidance in finding the right doctor, lab, convenience care or pharmacy • immediate connection to health coaches and other resources The goal of One Guide is to help Members take care of what matters most- staying healthy, saving money, and improving health.	**For HRA OAP** **and OAP Products:** **$3.50/employee/month Included in Medical Access Fee**

Health Improvement Fund		
Health Improvement Fund	For clinical/wellness/behavioral programs offered by CHLIC that are purchased, CHLIC will establish a Health Improvement Fund in the amount of $100,000.00. This fund will be used to defray the cost of CHLIC designated and arranged health and wellness improvement programs (e.g. biometric screenings, flu shots) for Employees of Employer and to reward participation in these programs. The Health Improvement Fund is a one-time credit to be used from July 1, 2020-June 30, 2021. Unused funds cannot be rolled over and CHLIC must pre-approve use of the Health Improvement Fund. The Health Improvement Fund shall be extinguished upon termination of this Agreement and any fund amount not used prior to termination of this Agreement shall only be available to Employer for the purpose of funding the cost of those reimbursable services provided prior to such termination.	

Exhibit B – Services

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

	Perform, based on CHLIC's book of business internal audits of plan benefit payments on a random sample basis.	**All Products**
	Claim control procedures reported annually in Statement on Standards for Attestation Engagements (SSAE) No. 18 Report (or any applicable successor thereto).	**All Products**
	Respond to Insurance Department complaints.	**All Products**
	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Products**
	Member Explanation of Benefit ("**EOB**") statements including, when applicable, notice of denied claims, denial reason(s) and appeal rights.	**All Products (excluding Pharmacy)**
	Verify enrollment and eligibility using Member information submitted by Employer and/or its authorized agent.	**All Products**
Medical Only		
	CHLIC's generic enrollment form is made available to Employer for individuals eligible to enroll in the Plan.	**All Medical Products**
	CHLIC's standard ID card with toll-free telephone number are prepared and mailed directly to Members.	**All Medical Products**
	Administration of subrogation/conditional Claim Payment (terms described in Exhibit E).	**All Medical Products**
Dental Only		
	CHLIC's generic enrollment form is made available to Employer for individuals eligible to enroll in the Plan.	**All Dental Products**
	CHLIC's generic ID cards are prepared and bulk shipped to the Employer's address to distribute to their employees.	**All Dental Products**
	Standard Dental predetermination of benefits for dental procedures on a voluntary basis.	**All Dental Products**
	When elected, the Cigna Oral Health Integration Program® (OHIP) includes the provision of administrative services necessary to provide eligible Members with certain health conditions enhanced dental benefits. The program covers the following conditions: Maternity, Diabetes, Cardiovascular Programs, cerebrovascular disease (stroke), chronic kidney disease, organ transplants and head/neck cancer radiation, and is aimed at improving overall health by encouraging Members to obtain needed dental treatment by providing enhanced benefits. As appropriate, OHIP may be expanded to include new procedures, conditions and programs in the future.	**All Dental Products**

Health Care Flexible Spending Account and Dependent Care Flexible Spending Account Only		
	Providing generic enrollment forms and reimbursement request forms to Employer for use in connection with Health Care Flexible Spending Account ("**FSA**") and/or Dependent Care Flexible Spending Account ("**DFSA**") under which eligible employees (collectively "**FSA Members**") may elect to reduce their salary on a pre-tax basis up to the IRS maximum contribution allowed for deposit into a FSA and/or DFSA.	**FSA and DFSA Products**
	At the end of each reimbursement period of the Plan Year, CHLIC shall issue payments to the extent that funds remain in each FSA Member's account, for the amount that is determined by it to be proper under the Plan. At the end of the final reimbursement period of the Plan Year, CHLIC shall issue payments for any amount then due for those expenses that are determined by it to be proper under the Plan.	**FSA and DFSA Products**
	Allowable expenses for reimbursement under a DFSA include all allowable expenses incurred for the care of dependents pursuant to I.R.C. Sections 125 and 129.	**DFSA Products**
	Allowable expenses for reimbursement under a FSA include all allowable health-related expenses, pursuant to I.R.C. Sections 125 and 213 except where reimbursement under a FSA is prohibited.	**FSA Products**
	FSA Member account balances will remain open after conclusion of the Plan Year until September 30th (the "**Run Out Period**"), so that FSA Members can submit any remaining expenses incurred during the Plan Year. For employees enrolled in the FSA on the last day of the Plan Year, claims incurred in the first 2 ½ months following the end of the Plan Year can also be submitted during the Plan run out period and applied to Plan Year unused funds. Separate account balances will be maintained as per FSA Member's election for the new Plan Year.	**FSA and DFSA Products**
	Reimbursement requests of terminating FSA Members will continue to be processed for 90 days following termination of FSA Membership for any expenses incurred prior to the FSA Membership termination date. In the case of a DFSA, reimbursement will be up to the balance in the DFSA and in the case of a FSA, reimbursement will be to the originally selected goal amount, minus prior reimbursements, regardless of whether this amount has been funded.	**FSA and DFSA Products**
	For FSA payments that are not made with a Debit Card but are a result of automatic claim forwarding ("**AutoPay**") of medical or dental claims from a medical or dental plan administered by CHLIC or Direct Submit Request For Reimbursement, an explanation of payment will be mailed to the FSA Member at their home address or, if elected, provided electronically. An explanation of payment is not issued for FSA payments that are issued to a pharmacy at the point of service as a result of automatic claim forwarding from the employee's pharmacy Plan.	**FSA Products**

	For DFSA payments made as a result of a Direct Submit Request For Reimbursement, an explanation of payment will be mailed to the DFSA Member at their home address or, if elected, provided electronically.	**DFSA Products**
	An 800 number directly linked to CHLIC's Member Services will be available for FSA Members' questions and status inquiries. This 800 number will be listed in the instructions on the reimbursement request form as well as having access to account information via Internet.	**FSA and DFSA Products**
	The Employer will identify through eligibility submission, FSA Members who elect to have medical and pharmacy claims processed but unpaid by CHLIC automatically submitted ("**rolled over**") to their FSA. Such rollover claims will be processed without additional submissions by the FSA Member and CHLIC shall be entitled to rely on the Employer's submission of the FSA Member's rollover election that the submitted expenses were properly incurred, not reimbursable from any other source and are eligible for payment under the regulations governing flexible spending accounts.	**FSA Products**
	When CHLIC takes over a FSA administration mid-Plan Year, CHLIC will provide administration services from the date CHLIC receives the FSA Plan information for claims incurred anytime during the Plan year.	**FSA and DFSA Products**
	For employees enrolled in a health care FSA plan with a debit card, a debit card will be issued to each FSA Member (employees enrolled in both a health care FSA plan with a debit card and a Health Reimbursement Account plan with a debit card will only receive one debit card covering both plans). The card is pre-loaded with the FSA Member's annual Health Care FSA goal amount for the Plan Year. Plan Year FSA funds are available using the debit card for transactions actually processed during the Plan Year period. The card does not access funds from a prior Plan period unless the Plan has the extended claim period and the Employee re-enrolls in the FSA for the subsequent period. If an Employee terminates their FSA Plan or does not re-enroll in the FSA, the debit card will be de-activated and will not be available for use after the last day of the Employee's FSA enrollment. The card is used by the FSA Member to access available FSA funds based upon the submitted goal amount less amount paid Plan Year to date from the fund. Since debits made with the card are not submitted by the card vendor to CHLIC in real-time but only on a daily basis, Employer agrees to fund all debits made by the FSA Member through the daily feed from the card vendor that indicates the FSA Member account is exhausted. The card is restricted to specific merchant types that are considered health care related. Although the card is limited to these types of merchants, the card does not limit specific items within these merchants. When the debit card is used, funds are automatically deducted from the FSA. FSA Members may be required to submit	**FSA Products**

	receipts to CHLIC to substantiate debit card expenditures. If appropriate substantiation is not received, the debit card will be suspended and no longer available for use.	
Health Reimbursement Account (HRA), Healthy Awards (HA) and Healthy Future (HF) Only		
	Providing reimbursement request forms to Employer.	**HRA Products**
	Employer will make available specific funds to eligible employees enrolled in the HRA, HA and/or HF as applicable (**"Participating Members"**). At the end of each reimbursement period of the Plan Year, CHLIC shall issue payments to Participating Members (or their medical provider, if appropriate) to the extent of the maximum amount of payment allowed by Employer reduced by prior reimbursements for the same period of coverage, for the amount that is determined by it to be proper under the Plan.	**HRA Products**
	Allowable expenses for reimbursement under a HRA, HA and/or HF, as applicable, include all allowable health-related expenses, pursuant to I.R.C. Section 213 except where payment for any such products is prohibited. The Employer can further limit the allowable expenses as agreed to by the Employer during implementation.	**HRA Products**
	Account balances for Participating Members active until the end of the Plan Year will remain open after conclusion of the Plan Year for a period of 90 days, (the "**Run Out Period**"), so that such Participating Members can submit any remaining expenses incurred during the Plan Year.	**HRA Products**
	A Participating Member's request to terminate his/her enrollment in the HRA, HA, and/or HF, as applicable, will continue to be processed for 90 days following termination for any expenses incurred prior to his/her termination date up to the originally selected goal amount, minus prior reimbursements.	**HRA Products**
	For reimbursement payments that are made as a result of automatic claim forwarding ("**AutoPay**") of medical claims from a medical plan administered by CHLIC or Direct Submit Request For Reimbursement, an explanation of payment will be made available to the Participating Member. An explanation of payment is not issued for payments that are issued to a pharmacy at the point of sale as a result of AutoPay from the employee's pharmacy Plan or for any Debit Card transactions.	**HRA Products**
	Providing information on account balances and submitted claims to Participating Members calling the number on the ID card. In addition, Participating Members will have access to account information via Internet and mobile app.	**HRA Products**

	When automatic claim forwarding ("**AutoPay**") is turned on, medical claims processed but unpaid by CHLIC will be automatically submitted for reimbursement from the HRA and/or HA Participating Member's HRA and/or HA account. Such "rollover" claims will be processed without additional submissions by the Participating Member.	**HRA Products**
	When CHLIC takes over HRA, HA and/or HF administration mid-Plan Year, CHLIC will provide administrative services from the date the Plan information is received.	**HRA Products**
	For employee enrolled in an HRA, HA and/or HF Plan with a debit card, a debit card will be issued to each HRA, HA and/or HF participating employee and spouse (if spouse is enrolled in the Plan). A debit card will also be issued upon Employee request to other eligible dependents (employee enrolled in both a health care FSA Plan with a debit card and a Health Reimbursement Account Plan with a debit card will only receive one debit card covering both Plans). The card is pre-loaded with the Participating Member's annual HRA, HA and/or HF goal amount for the Plan Year. If additional funds are added during the plan year, the card balance will automatically be adjusted. Plan Year HRA, HA and/or HF funds are available using the debit card for transactions actually processed during the Plan Year period. The card will access funds from a prior Plan period when the employee re-enrolls in the HRA, HA and/or HF for the subsequent period and has remaining HRA, HA and/or HF funds that carry over to the new period, and the debit card was active for the prior plan period. If an employee terminates their HRA, HA and/or HF Plan or does not re-enroll in the HRA, HA and/or HF the debit card will be de-activated and will not be available for use after the last day of the employee's HRA, HA and/or HF enrollment. The card is used by the HRA, HA and/or HF Participating Member to access available HRA, HA and/or HF funds based upon the submitted goal amount plus any added incentive reward dollars (if applicable) less amount paid Plan Year to date from the fund. Since debits made with the card are not submitted by the card vendor to CHLIC in real-time but only on a daily basis, Employer agrees to fund all debits made by the Participating Member indicated through the daily feed from the card vendor, until the Participating Member's account is exhausted. The card is restricted to specific merchant types that are considered health care related based on service category elections. Although the card is limited to these types of merchants, the card does not limit specific items within these merchants, unless they are an inventory information approval system ("IIAS") merchant with The Special Interest Group for IIAS Standards ("SIGIS"). When the debit card is used, funds are automatically deducted from the HRA, HA and or HF. HRA, HA and/or HF Participating Members may be required to submit receipts to CHLIC to substantiate debit card	**HRA Products**

	expenditures. CHLIC will attempt to obtain the appropriate documentation from the participant via mail or email. If appropriate documentation to substantiate the transaction is not received, the debit card will be suspended and no longer available for use.	
	Pharmacy claims: Eligible pharmacy expenses, under the HRA and/or HA that are processed but unpaid by CHLIC may be automatically submitted ("rolled over") to the Reimbursement Accounts Claim Office for reimbursement from the Participating Member's HRA, HA and/or HF account if the AutoPay option is enabled. Such rollover claims will be processed without additional submissions by the Participating Member. When pharmacy is covered and Cigna Pharmacy is the pharmacy vendor, the HRA and/or HA will automatically pay the pharmacy through the HRA and/or HA at the point of sale for all Participating Member obligations under the pharmacy Plan including deductibles, copays, and/or coinsurance obligations. A Participating Member will not receive an Explanation of Benefits for these payments.	**HRA Products**
PLAN BOOKLET		
Products excluding Health Savings Account		
	Prepare and make accessible Member benefit booklet drafts to Employer.	**All Products**
UNDERWRITING SERVICES		
	5500 Schedule C reporting.	**All Products**
	5500 Schedule A or Annual Reconciliation Disclosure reporting (when applicable)	**All Products**
	CHLIC's standard Underwriting services: a) benefit design analysis b) projected cost analysis.	**All Products**
HIPAA INDIVIDUAL RIGHTS		
Products excluding Health Savings Account		
	Handling of requests from Members for access to, amendment and accounting of protected health information, and requests for restrictions and alternative communications as required under federal HIPAA law and regulations, as set out in this Agreement and its Exhibits.	**All Products**
COST CONTAINMENT		
	Maximum reimbursable charge determinations of non-Participating Provider charges for covered services.	**All Medical Products (with out-of-network benefits)**
	CHLIC's standard cost containment controls: Application of non-duplication and coordination of benefits rules and coordination with Medicare.	**All Medical Products**

	Delivery of information, as necessary, regarding standard application of non-duplication or coordination of benefits.	**All Medical and Dental Products**
	Review of medical bills in accordance with CHLIC's then current Medical Bill Review program.	**All Medical Products**
	Dental Cost Containment, a network of additional participating PPO providers that provide discounts for which CHLIC retains a portion of the savings generated.	**All Dental Products**
	Network Savings Program, a national vendor network that provides discounted rates when a Member accesses care through a Network Savings Program contracted provider.	**All Medical Products**
	Annual reporting of CHLIC's standard cost containment results upon Employer's request.	**All Medical and Dental Products**
	Pharmacy Vendor Recoveries.	**All Pharmacy Products**
	CUSTOMER REPORTING	
	Summary reports of medical, dental and pharmacy cost and utilization experience (where applicable), upon completion of internal report generation, are available through Cigna's web site, CignaAccess.com.	**All Medical, Dental and Pharmacy Products**
	CHLIC's standard pharmacy utilization reports.	**Pharmacy Product Only**
	Claim Reporting: CHLIC will provide standard banking and financial report information based upon paid claim data. CHLIC will not provide information on incurred-but-not reported claims, projected claims, pre-certifications of coverage, case management information or information on a Member's prognosis or course of treatment. Stop Loss Reporting is an optional service provided at an additional fee to Employers who have stop loss through another entity other than CHLIC. CHLIC will provide its standard reporting only after the stop loss carrier and Employer have executed CHLIC's standard Hold Harmless/Confidentiality Agreement.	**All Medical Products**
	CHLIC's standard management and statistical reports for Employer.	**FSA and DFSA Products**
	CHLIC's standard Individual Summary Statements for applicable participating Members.	**FSA, DFSA and HRA Products**
	CHLIC's standard Health Reimbursement Account, Healthy Awards and/or Healthy Future activity report for Employer.	**HRA Products**

	COMPLIANCE	
	Employer directs CHLIC in administering the Health Care Flexible Spending Account, Healthy Awards, Healthy Futures and/or Health Reimbursement Account benefit to comply with COBRA as follows:	
	Each FSA Member who experiences a qualifying event and elects continuation of account coverage in accordance with COBRA will be maintained until the earlier of the end of the Plan Year, the exhaustion of the FSA balance or other termination of the FSA.	**FSA Products**
	FSA Members electing continuation of FSA coverage under COBRA will continue contributions at a rate not to exceed 102% of the applicable premium. The Employer may require after-tax contributions, or may allow the continuant to elect a lump-sum salary reduction in the amount required in contributions for the remainder of the coverage period.	**FSA Products**
	FSA Members who continue under COBRA and whose contributions have been made as required may submit Reimbursement Requests for themselves and any eligible dependents, for expenses incurred before or after the date of the qualifying event but prior to the end of the coverage period. Requests may be submitted until the earlier of the end of the Plan Year or the termination of the FSA, including any applicable Run-Out Period.	**FSA Products**
	The HRA, HA and/or HF of each HRA, HA and/or HF Participating Member who experiences a qualifying event and elects continuation of account coverage in accordance with COBRA will be maintained similar to the maintenance of an active employee. HF Participating Members that have not met their vesting requirements determined by the plan are not required to be offered COBRA for the HF.	**HRA Products**
	MEMBER EXTERNAL REVIEW PROGRAM	
	CHLIC contracts with a minimum of three (3) independent review organizations that meet the Patient Protection and Affordable Care Act (PPACA) external review requirements. Members may appeal eligible claims requiring medical judgment to an external independent review organization which is selected by CHLIC on a random basis. If Employer has chosen not to participate in this program, the Employer may be responsible for making other arrangements to meet the Patient Protection and Affordable Care Act (PPACA) external review requirements.	**All Medical Products**

MEDICAL MANAGEMENT SERVICES		
	CHLIC provides integrated medical management that includes (depending upon the terms of the Plan) the following core services.	
	Pre-Admission Certification and Continued Stay Review (PAC/CSR) services to certify coverage of acute and sub-acute inpatient admissions/stays or provides guidance to appropriate alternative settings. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products**
	Case Management, a service designed to provide assistance to a Member who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support.	**All Medical Products**
	Assist providers with resources and tools to enable them to develop long term treatment plans in the management of chronic or catastrophic cases.	**All Medical Products**
	The Cigna HealthCare Healthy Babies® Program is a one-time educational mailing which provides Participants with prenatal care education and resources to help them better manage their pregnancy. Other benefits of this program include the Health Information Line℠ and pregnancy information on myCigna.com.	**All Medical Products**
	HealthCare Cost and Quality tools available on myCigna.com and myCigna mobile app.	**All Medical Products**
	A panel of physicians and other clinicians to assess the safety and effectiveness of new and emerging medical technologies. The panel meets monthly to review and update coverage policies.	**All Medical Products**
	The Health Information Line℠ is a service that provides twenty-four (24) hour toll free access to nurses, who provide answers to healthcare questions, recommend appropriate settings for care and assist Participants in locating physicians. It also includes access to an extensive audio library, available on myCigna.com, on a wide range of medical topics.	**All Medical Products**
	Cigna LifeSOURCE Transplant Network® contracts with more than one hundred sixty-five (165) independent transplant facilities which includes over seven hundred fifty (750) transplant programs and provides access to solid organ and bone marrow/stem cell transplantation while improving cost containment and reducing financial risk.	**All Medical Products**
	A health education program that delivers mailings to Members with certain conditions.	**All Medical Products**

	Behavioral health services are provided/arranged by Cigna Behavioral Health (CBH), CBH provides utilization review and case management for both inpatient and outpatient, in-network behavioral health services.	**HRA OAP and OAP Products: (All Members)**
	Implement clinical quality measurements, track and validate performance and initiate continuous quality improvement.	**All Medical Products**
	Transition of care services to allow Members with defined conditions to continue treatment with non-Participating Providers after enrollment for continued uninterrupted care for a limited time.	**All Medical Products Except Comprehensive and Indemnity**
	Focused utilization management of outpatient procedures and identification of appropriate alternatives. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products with Care Management Preferred**
NETWORK MANAGEMENT SERVICES		
	CHLIC, and/or its affiliates or contracted vendors shall:	
	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, fixed per person per period, per diem charges, incentive bonuses, case rates, withholds etc.). The amount and type of negotiated reimbursement may vary depending upon the type of plan. For example, a hospital may accept less for patients enrolled in certain types of plans than others; In addition, CHLIC may contract with Participating Providers and other parties (for example Independent Practice Associations) for performance-based incentive payments to promote quality of care, patient safety and cost efficiency.	**All Medical and Pharmacy Products**
	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, fixed per person per period, per diem charges, incentive bonuses, case rates, withholds etc.). In addition, CHLIC may contract with Participating Providers and other parties for performance-based incentive payments to promote quality of care, patient safety and cost efficiency;	**All Dental Products**

	Credential and re-credential Participating Providers in accordance with CHLIC's credentialing requirements and ensure that third-party network vendors credential/re-credential Participating Providers in accordance with CHLIC's requirements;	**All Medical, Dental and Pharmacy Products**
	Monitor Participating Provider compliance with protocols and procedures for quality, Member satisfaction, and grievance resolution;	**All Medical, Dental and Pharmacy Products**
	Facilitate the identification of Participating Providers by Members; and	**All Medical, Dental and Pharmacy Products**
	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Medical, Dental and Pharmacy Products**
	Access to online and/or on demand medical and health-related consultations via secure telecommunications technologies, telephones and internet where permitted only when delivered by a CHLIC contracted medical Telehealth network of providers (see details on myCigna.com).	**All Medical Products**
	BEHAVIORAL HEALTH	
	CHLIC has contracted with an affiliate, Cigna Behavioral Health ("CBH"), to provide or arrange for the provision of managed in-network behavioral health services, CBH is a Participating Provider, and is reimbursed primarily on a monthly fixed fee basis. This fixed fee for CBH services will be paid as claims and will appear in Employer's monthly reporting and on financial documents. Such payments will be at the relevant monthly rates then in effect. The monthly rates paid to CBH vary depending on geographic location of Members and on benefit design, and may be subject to change. The rates will be made available upon request. The fixed fee also includes lifestyle management programs, a cognitive behavioral modification program, a Complex Psychiatric Case Management program, and a Narcotics Therapy Management program. Behavioral claims from a client specific network are not included in the behavioral monthly fixed fee and will be paid from the Bank Account. In some states, payment for behavioral health services must be paid on a fee-for-service basis. In these states, fee-for-service payments for behavioral health services and the CBH administrative fee (including the lifestyle management programs, a cognitive behavioral modification program a Complex Psychiatric Case Management program and a Narcotics Therapy Management program) will be paid from the Bank Account as claims and will appear in Employer's monthly reporting.	**These services are included in the following products:** **HRA OAP** **and OAP Products**

CIGNA STAFF MODEL HEALTHPLAN SERVICES		
	The Cigna HealthCare of Arizona, Inc. staff model ("**Cigna Medical Group**" or "**CMG**") is a multispecialty participating provider group located in metropolitan Phoenix, Arizona. CMG's integrated care delivery model and population health management team work together to facilitate the way in which patients and doctors communicate and interact in order to increase patient satisfaction and improve health outcomes. Plan Participants may at some time receive treatment from a CMG facility or provider even if they do not reside in Arizona (as when traveling). Plan Participants utilizing Cigna participating provider networks in Arizona may access certain specialty and/or ancillary services (such as imaging and urgent care services) through the CMG system. For covered services provided to Participants, CMG is paid at the rates in effect at the time of service (as may be revised from time to time). Representative rates for routinely performed services are attached to the Schedule of Financial Charges herein. A complete copy of the rates is available on request under a mutually agreed nondisclosure agreement ("**NDA**"). If the Plan requires or allows Participants to select a primary care provider ("**PCP**"), Phoenix area Participants who do not select a PCP during open enrollment may be assigned to or otherwise encouraged to consider a CMG PCP. CMG has established collaborative referral relationships with specialty and ancillary providers in Cigna's participating provider networks, which includes affiliated entities CMG may also receive applicable performance-based incentive payments for its participation in programs designed to improve quality, patient safety and affordability. The incentive payments that CMG may receive will be determined using the same performance measures and reward formula as used in determining the incentive payments made to similarly situated non-Cigna affiliated provider entities. The amount of the incentive payments made to CMG and attributable to the plan will be provided upon request.	**All Medical Products**

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

EFFECTIVE JANUARY 1, 2020

(Applicable to Open Access Plus Products)

Department	CPT Code*	Description	Rate
All Departments	99213	OFFICE VISIT,EST EXP PROB FOC	$73.81
Adult Medicine	99396	WELL EXAM, EST, 40-64 YEARS	$126.72
Pediatrics	99392	WELL EXAM, EST, 1-4 YEARS	$106.46
Ophthalmology	66984	REMOVE CATARACT, INSERT LENS-Professional Fee only, at a facility	$641.43
Podiatry	11721	DEBRIDEMENT NAIL SIX OR MORE	$45.51
Radiology	71046	CHEST X-RAY, PA & LAT	$31.28
Radiology	77067 & 77063	SCREENING MAMMOGRAPHY DIGITAL	$189.64
General Surgery	47562	LAPAROSCOPY;CHOLECYSTECTOMY-Professional Fee only, at a facility	$666.13
Optometry	92014	EYE EXAM & TREATMENT	$126.12
ASC (Ambulatory surgical center) / Endoscopy Suite	Grouper 2		$457.77
ASC Endoscopy Suite	Grouper 8		$998.69

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

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

CMG pharmacy rates:

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

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

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

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

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

Appendix A – Pharmacy Benefit Management Services

PHARMACY BENEFIT MANAGEMENT - DEFINITIONS

Definitions

Any capitalized term not defined below shall have the meaning given to such term in the Agreement. Any capitalized term utilized in the Schedule of Financial Charges or Exhibit B shall have the meaning given to such term in the Agreement, including the meanings set forth below.

- "Actuarially Estimated" shall mean that the discount(s) listed in the Schedule of Financial Charges are estimated, but not guaranteed, to result in a particular average discount for Covered Drugs administered by CHLIC under this Agreement. Actuarially estimated discounts are calculated based on evaluation of an expected distribution of drug utilization across CHLIC's aggregate group client book of business. As measured in the aggregate for Employer's Pharmacy Benefit, Employer's average discount results may vary based on the Plan-specific factors such as drug mix utilization.

- "Authorized Generic" shall mean a pharmaceutical product sold, licensed, or marketed under a new drug application (NDA) approved by the Food and Drug Administration (FDA) under section 505(c) of the Federal Food, Drug and Cosmetic Act (FFDCA) that is marketed, sold or distributed under a different labeler code, product code, trade name, trademark, or packaging (other than repackaging the listed drug for use in institutions) than the innovator brand name drug.

- "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"), Covered Drug specific, quantity appropriate actual package size (or the manufacturer-packaged quantity closest to the dispensed size), submitted by a Retail Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy 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, including, for example, any change in the markup, methodologies, processes or algorithms underlying the published AWP(s), CHLIC may adjust any or all of the Rebates, charges, rates, discounts, guarantees and/or fees in connection with CHLIC's administration of the Pharmacy Benefit hereunder, including any that are based on AWP, as it reasonably deems necessary to preserve the economic value or benefit of this Agreement to CHLIC as it existed immediately prior to such change. Additionally, and notwithstanding any other provision in this Agreement, CHLIC may replace AWP as its pharmaceutical pricing benchmark with an alternative benchmark and/or may replace Medi-Span, or other such publication, as its source for the AWP or alternative benchmark with a different pricing source, provided that CHLIC adjusts any or all such AWP-based charges or such alternative benchmark-based charges as it reasonably deems necessary to preserve the economic value or benefit of this Agreement to CHLIC as it existed immediately prior to such replacement or immediately prior to the event(s) giving rise to such replacement, as the case may be.

- "Biosimilar" shall mean a biological product that is licensed by the FDA as a biosimilar pursuant to Section 351(k) of the Public Health Service Act, 42 U.S.C. 262(k), based upon a showing that it is highly similar to a single FDA-licensed biological product, known as a reference product, and has no clinically meaningful differences compared to the reference product in terms of safety, purity, and potency. A biosimilar biological product may be licensed by the FDA as biosimilar or interchangeable, and in either case such biological product is a Biosimilar for the purposes of this Agreement.
- "Brand Drug" shall mean a pharmaceutical product, including a Covered Drug that is a prescription drug, including over-the-counter drugs dispensed pursuant to a prescription, medicine, agent, substance, device, supply or other therapeutic product that is not a Generic Drug. Except if and where the language expressly states otherwise, a Brand Drug does not include a Specialty Brand Drug for ingredient cost discount purposes.
- "Business Decision Team" shall mean a committee comprised of voting and non-voting representatives across various Cigna business units such as clinical, medical and business leadership that is duly authorized by Cigna to make decisions regarding coverage treatment of pharmaceutical products based on clinical findings provided by the P&T Committee, including, but not limited to, decisions regarding tier placement and application of utilization management to pharmaceutical products.
- "Cigna Home Delivery Pharmacy" shall mean a duly licensed pharmacy operated by CHLIC or its affiliates, where prescriptions are filled and delivered via the mail service, which may include, for example, Accredo Health Group, Inc., ESI Mail Pharmacy Service, Inc., Express Scripts Pharmacy Inc., Tel-Drug of Pennsylvania LLC and Tel-Drug, Inc.
- "Claim," for purposes of this Appendix A, is a claim or request for coverage under the Pharmacy Benefit.
- "Compound Drug" shall mean a medication that (a) is comprised of two or more gaseous, solid, semi-solid, or liquid ingredients (other than water or flavoring added to any preparation) that are weighed or measured at a pharmacy and then prepared according to the prescriber's order and the pharmacist's art; (b) contains at least one FDA-approved federal legend drug as an active ingredient; (c) is not otherwise generally available in its compound form; and (d) is not a compound preparation administered by infusion or injection.
- "Covered Drugs" shall mean prescription drugs, including over-the-counter drugs dispensed pursuant to a prescription, biologics, medicines, agents, substances, devices, supplies, and other therapeutic products that are prescribed for Members and are covered under the Pharmacy Benefit and shall include all associated standard services usually and customarily rendered by a pharmacy or provider in the normal course of business, including dispensing, administration, counseling and product consultation.
- "Dispensing Fee" means an amount paid to a pharmacy for providing professional services necessary to dispense a Covered Drug to a Member.

- "FDA" shall mean the U.S. Food and Drug Administration.
- "Formulary" shall mean the list of FDA-approved prescription drugs and supplies developed and managed by CHLIC across its self-funded and insured group book of business and that is selected and adopted by Employer. The drugs and supplies included on the Formulary will be modified by CHLIC from time to time as a result of factors including, but not limited to, economic and clinical factors like clinical appropriateness, manufacturer Rebate arrangements and patent expirations. Any changes CHLIC makes to the Formulary are hereby adopted by Employer.
- "Generic Drug" means a pharmaceutical product, including a Covered Drug, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the FDA as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient(s), and which is identified as such in CHLIC's master drug file using indicators from First Databank, Medi-Span, or other nationally recognized source as used by CHLIC across its book of business on the basis of a proprietary algorithm, a summary of which may be made available for review by Employer or, subject to CHLIC's consent, its auditor upon request in accordance with the terms set forth in this Appendix A. Employer and, as applicable, its auditor shall sign a confidentiality agreement acceptable to CHLIC relating specifically to such summary. The reference to a drug by its chemical name does not necessarily mean that the product is recognized as a generic for adjudication, pricing or copay purposes. Except if and where the language expressly states otherwise, a Generic Drug does not include a Specialty Generic Drug for ingredient cost discount purposes. For pricing purposes, a Generic Drug excludes a Covered Drug that is either marketed under three (3) or fewer Abbreviated New Drug Application pursuant to 21 U.S.C. §355, and its implementing regulations, or cannot be purchased by the pharmaceutical industry at large from more than one (1) pharmaceutical wholesaler. For pricing purposes, a Generic Drug also excludes a Biosimilar.
- "Maximum Allowable Charge" shall mean the maximum unit price for a Covered Drug included on the applicable MAC List as set forth on such MAC List.
- "MAC List" shall mean a then-current list maintained by CHLIC of prescription drugs, devices, supplies and over-the-counter drugs identified as readily available as a Generic Drug or generally equivalent to a Brand Drug (in which case it may also be on a MAC List) and that, in each case, are deemed to require or are otherwise capable of pricing management due to the number of manufacturers, utilization and/or pricing volatility.
- "Manufacturer Administrative Fees" shall mean administrative fees paid by pharmaceutical manufacturers to CHLIC or its affiliate or subcontractor directly in connection with administering, invoicing, allocating and collecting Rebates.
- "Pharmacy Benefits" shall mean amounts payable for covered pharmacy benefit services and products under the terms of the Plan; Pharmacy Benefits shall be considered Plan Benefits for purposes of this Agreement.

- "P&T Committee" shall mean a committee comprised of clinicians that represent a range of clinical specialties. The committee regularly reviews pharmaceutical products, new pharmaceutical products, for safety and efficacy, the findings of which clinical reviews inform coverage status decisions made by the Business Decision Team. The P&T Committee's review may be based on consideration of, without limitation, FDA-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

- "PBM Proprietary Information" shall mean information relating to CHLIC's pharmacy benefit management products and services, including, without limitation, CHLIC's reporting and web-based applications, eligibility and adjudication systems and coding methodologies, system formats and databanks, clinical or formulary management operations or programs, information and agreements relating to Rebates and other financial information, prescription drug evaluation criteria and coverage policies, drug pricing information, including MAC List and Specialty Drug pricing, paid Claims information integrated into CHLIC's adjudication systems, and pharmaceutical manufacturer, vendor or pharmacy network agreements.

- "Prescription Drug Charge" shall mean the amount that, prior to application of the Plan's cost-share requirement(s), Employer is obligated to pay for a Covered Drug dispensed at a Retail Pharmacy or Cigna Home Delivery Pharmacy, including any ingredient cost, applicable Dispensing Fee, service fee, and tax. The ingredient cost charged to Employer may be expressed as, for example, a discount off of AWP or other benchmark price, or a MAC.

- "Rebate" shall mean the following payments or other consideration paid or payable to CHLIC from manufacturers to the extent arising from or as a result of Covered Drugs dispensed to Members and/or the performance of any pharmacy benefit management services provided under the Agreement.

  (a) Payments, rebates and other consideration paid to CHLIC from any manufacturer arising from or as a result of the inclusion or exclusion on any Formulary of Covered Drugs manufactured, sold, marketed, or distributed by any manufacturer;

  (b) Rebates, discounts, service fees and other consideration paid to CHLIC from any manufacturer arising from or as a result of any arrangements, commitments, programs or activities involving or relating to utilization (e.g., market share, growth, etc.) of certain prescription drugs within their respective therapeutic categories; and

  (c) Rebates, discounts, service fees and other consideration paid to CHLIC from any manufacturer arising from or as a result of any arrangements, commitments, programs or activities involving or relating to services performed by CHLIC where CHLIC is paid or is entitled to fees or other compensation on the basis of the volume or value of prescription drugs or other products that are prescribed or dispensed to CHLIC customers.

However, "Rebates" shall exclude: (i) pricing adjustments, payments and credits made in the ordinary course by any manufacturer on account of product returns, delivery errors or shipping damage or losses arising from drugs and other products purchased from such manufacturer by or on behalf of CHLIC (ii) pricing discounts paid or credited by a manufacturer to pharmacies affiliated with CHLIC for prescription drugs and other products purchased from such manufacturer; (iii) any fees or other compensation paid by any manufacturer in consideration of any services, products, activities or programs performed, provided or implemented by CHLIC or any of its affiliates for such manufacturer; (iv) Manufacturer Administrative Fees; (v) Value-Based Payments; (vi) any rebates or other amounts that are allocated to reduce and/or partially or wholly satisfy a Member's cost-sharing obligation for a Covered Drug; and (vii) rebates or other amounts paid to CHLIC for prescription drugs that are administered or otherwise provided to Members in providers' offices, home health care settings, or outpatient clinics.

- "Retail Pharmacy" shall mean any licensed retail pharmacy with which CHLIC has contracted directly or indirectly with a third party, to provide Covered Drugs to Members, and is not a mail order pharmacy. A mail order pharmacy is a pharmacy that primarily fills and delivers pharmaceutical products via the mail service. The term "Retail", when immediately preceding the term "Brand Drug Claim", "Generic Drug Claim", "Specialty Drug Claim", "Specialty Brand Drug Claim", or "Specialty Generic Drug Claim" means that the resulting term (e.g., "Retail Brand Drug Claim") refers to such claim as dispensed by a Retail Pharmacy.

- "Specialty Drug" shall mean a pharmaceutical product, including a Covered Drug, considered by CHLIC to be a Specialty Drug based on consideration of the following factors: (i) whether the pharmaceutical product is prescribed and used for the treatment of a complex, chronic or rare condition; (ii) whether the pharmaceutical product has a high acquisition cost; and, (iii) whether the pharmaceutical product is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Drug may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a pharmaceutical product will be considered a Specialty Drug. The term "Specialty," when immediately preceding the terms "Generic Drug" or "Brand Drug", means that the resulting term (e.g. "Specialty Generic Drug") refers to a Generic Drug or Brand Drug that is considered a Specialty Drug, respectively.

- "Specialty Pharmacy" shall mean a duly licensed pharmacy designated by or operated by CHLIC or its affiliates that primarily dispenses Specialty Drugs or provides services related thereto; provided, however, that when the Cigna Home Delivery Pharmacy dispenses a Specialty Drug, it shall be considered a Specialty Pharmacy hereunder.

- "U&C Charge" shall mean the price the applicable Retail Pharmacy would charge a regular cash-paying customer for a Covered Drug (and any services related to the dispensing thereof) on the day on which the Covered Drug is dispensed.

PHARMACY BENEFIT MANAGEMENT - SERVICES TO BE PROVIDED

1. Retail Pharmacy Network.

(a) General. CHLIC shall maintain a Retail Pharmacy network. Retail Pharmacies included in the network shall provide Covered Drugs to which the Retail Pharmacies have access to Members during their normal business hours in all applicable locations. A list of the Retail Pharmacies included in the network, as updated from time to time, shall be made available to Members online. CHLIC maintains multiple networks and/or sub-networks and may periodically consolidate networks and/or migrate clients, including Employer, between networks and sub-networks. CHLIC shall require each Retail Pharmacy included in the network to meet its requirements for participation in the Retail Pharmacy network, which include, but are not limited to, satisfaction of licensing and insurance requirements.

(b) Retail Pharmacy Audits and Overpayments. CHLIC shall perform desktop and on-site audits of each Retail Pharmacy to ensure that each Retail Pharmacy is complying with the terms of its contract with CHLIC. In the event that CHLIC discovers that an overpayment has been made to a Retail Pharmacy, CHLIC shall take reasonable steps to recover the overpayment pursuant to the terms of this Agreement.

(c) Independent Contractors. The Retail Pharmacies are independent contractors, and CHLIC does not exert direction or control over the pharmacists at Retail Pharmacies in filling prescriptions or performing other pharmaceutical services.

(d) Collection of Cost Sharing. CHLIC shall require Retail Pharmacies to collect all applicable Plan cost-shares from Members.

2. Cigna Home Delivery Pharmacy.

(a) General. Members may submit new or refill prescription orders for fulfillment through Cigna Home Delivery Pharmacy or such other mail service pharmacy that CHLIC in its sole discretion may select from time to time. Such orders may be placed via mail, telephone, or electronic means. Subject to Applicable Law, Employer shall permit CHLIC to communicate with Members regarding availability and use of the Cigna Home Delivery Pharmacy and potential cost savings associated therewith. In addition, CHLIC may provide supporting services with respect to the Cigna Home Delivery Pharmacy. Cigna Home Delivery Pharmacy shall deliver all drugs to Members in accordance with its standard procedures. For the purposes of clarity, CHLIC does not exert direction or control over the pharmacists at Cigna Home Delivery Pharmacy in filling prescriptions or performing other pharmaceutical services.

(b) Cost Sharing. Members are responsible for payment of the applicable cost sharing to Cigna Home Delivery Pharmacy for each prescription or prescription refill. Employer acknowledges that Cigna Home Delivery Pharmacy may suspend services to a Member who is in default of any cost-sharing obligations, in accordance with Cigna Home Delivery Pharmacy's standard credit

policy. If payment of such cost-sharing has not been received from the Member within one hundred twenty (120) days of dispensing of the product, the Plan will be billed for the outstanding amount following the one hundred twenty (120) day collection period.

(c) Affiliation with CHLIC. Accredo Health Group, Inc., ESI Mail Pharmacy Service, Inc., Express Scripts Pharmacy Inc., Tel-Drug of Pennsylvania LLC and Tel-Drug, Inc. are licensed pharmacy affiliates of CHLIC that fill and deliver Covered Drugs via the mail service.

3. **Claims Processing**.

(a) General. CHLIC, in accordance with Section 2 of the Agreement, shall perform claims processing services for Covered Drugs dispensed by Retail Pharmacies or Cigna Home Delivery Pharmacy. In-network Claims shall be submitted via paper or electronically. Members using out-of-network covered services are required to submit a paper claim form. A separate charge shall apply for submission of any paper claim form, whether in-network or out-of-network. CHLIC is not required to provide coordination of benefits (COB) services for Claims for drugs dispensed, and electronically processed, at a pharmacy; Claims may be processed without consideration of a Member's coverage under another plan.

(b) Drug Utilization Review. CHLIC shall perform a concurrent Drug Utilization Review ("DUR") analysis of each prescription submitted for processing, which may include, for example: (1) prescribed dosage within a safe range; (2) drug-to-drug interaction; (3) drug-to-allergy interaction; (4) age-to-drug interaction; (5) duplicate therapy; (6) quantity limitations; and (7) days' supply. CHLIC's DUR processes shall not override or substitute for the prescriber's, the pharmacist's or other health care provider's professional judgment.

4. **Utilization Management Program**. CHLIC shall, in accordance with Section 2 of the Agreement, administer the Pharmacy Benefit utilization management program(s) identified in this Agreement. Employer acknowledges that CHLIC's coverage policies and claims administration procedures, which are utilized across CHLIC's self-funded and insured book-of-business to adjudicate claims and administer appeals, may change periodically. As an example of the coverage criteria that may apply to a pharmaceutical product, a Member may have to try one or more preferred pharmaceutical products, or demonstrate why trying the preferred pharmaceutical product(s) would be clinically inappropriate, in order to obtain coverage under the Plan for a given pharmaceutical product Employer further authorizes CHLIC to allow coverage for a use that would be otherwise excluded in the event of co-morbidities, complications and other factors not expressly addressed by the coverage policies utilized by CHLIC in reviewing Claims for coverage. CHLIC may rely wholly upon information about the Member and the prescriber's diagnosis of the Member's condition. CHLIC shall not substitute its judgment for the judgment of the prescribing physician, nor shall it determine medical necessity or make other medical determinations other than for coverage purposes.

5. **Rebate Management**. CHLIC shall pay Employer amounts equal to the Rebate amounts specified in the Schedule of Financial Charges.

6. **Drug-Related Services**.

(a) Specialty Drugs. CHLIC shall process Claims regarding Specialty Drugs subject to the following provisions:

(1) The Specialty Pharmacy shall fill prescriptions for Specialty Drugs based on the professional judgment of the dispensing pharmacist, accepted pharmacy practices and product guidelines.

(2) A list of Specialty Drugs available via the Specialty Pharmacy and pricing with respect thereto shall be made available as in effect on the Effective Date, are set forth in Appendix B. After the Effective Date, Employer may request that CHLIC provide it with an updated list of Specialty Drugs available via the Specialty Pharmacy and pricing with respect thereto.

(3) To the extent acting in the capacity as a mail order pharmacy, the Specialty Pharmacy shall ship Specialty Drugs to Members in accordance with its standard procedures.

(4) Members are responsible for payment of the applicable cost sharing to the Specialty Pharmacy for each prescription or prescription refill. Employer acknowledges that the Specialty Pharmacy may suspend services to a Member who is in default of any cost-sharing obligations, in accordance with the Specialty Pharmacy's standard credit policy. If payment has not been received from the Member within one hundred twenty (120) days of dispensing, the Plan will be billed following the one hundred twenty (120) day collection period.

(5) For the purposes of clarity, CHLIC does not exert direction or control over the pharmacists at the Specialty Pharmacy in filling prescriptions or performing other pharmaceutical services.

(b) Compound Drugs. CHLIC shall process prescribed Compound Drugs to the extent covered under the Plan. CHLIC shall treat as Covered Drugs only those components of a Compound Drug that would otherwise be treated as Covered Drugs were they not part of a Compound Drug.

7. **Member Communications and Services**.

(a) Member Communication. CHLIC shall provide to Members an ID card and instructions to access Member materials online, including the Formulary, the Retail Pharmacy directory, Cigna Home Delivery Pharmacy information, and an out-of-network Claim reimbursement form.

(b) Rx Savings Messenger. CHLIC may send personalized mailings to Members regarding the Generic Drugs and preferred Brand Drugs and savings available from Cigna Home Delivery Pharmacy.

(c) Call Center. CHLIC shall maintain toll-free customer service lines twenty-four (24) hours per day, seven (7) days per week for the purpose of responding to inquiries from Members regarding Retail Pharmacy, Cigna Home Delivery Pharmacy or Claims issues.

8. Formulary Management; Clinical Programs; Other Services.

CHLIC shall provide Formulary management services, which shall include implementing Formulary placement decisions and determinations to apply utilization management requirements made by CHLIC's Business Decision Team. The Business Decision Team makes Formulary determinations based on consideration of clinical and economic factors. Clinical factors may include, but are not limited to, the CHLIC P&T Committee's evaluation of the place in therapy, relative safety or relative efficacy of the drug, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the drug's acquisition cost including, but not limited to, assessments on the cost effectiveness of the drug and available Rebates. Employer acknowledges that the Formulary, utilization management requirements, and coverage policies used by CHLIC to perform coverage reviews, including any changes made thereto, are adopted by Employer. When considering a drug for Formulary placement or other coverage conditions, CHLIC's Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its relevant book-of-business. CHLIC may also provide the clinical, safety and/or trend programs, or other programs and services to Employer, some of which may require payment of additional fees by Employer. If additional fees are required for such a program or service, CHLIC shall include the fee in the Schedule of Financial Charges or otherwise communicate the same in writing to by Employer.

PHARMACY BENEFIT MANAGEMENT - PROGRAM OPERATIONS

1. Implementation of Agreement.

(a) Project Plan. Employer and CHLIC shall develop an agreed upon implementation project plan with respect to the Agreement prior to the Effective Date or prior to the implementation with respect to any new Pharmacy Benefit under this Agreement following the Effective Date.

(b) Initial Data and Commencement of Pharmacy Benefit Management Services. Prior to the Effective Date, Employer shall provide CHLIC with all data and/or documentation necessary for CHLIC to provide the services specified in this Agreement. Such data and/or documentation shall include, but is not necessarily limited to, claims history and Member prior authorization history. Assuming all data specified in the preceding sentence is received sufficiently in advance of the Effective Date, CHLIC shall commence providing services under this Agreement as of the Effective Date.

2. **Timely Provision of Data by Employer**. Employer acknowledges that CHLIC shall not be held responsible for, and shall be released from, fulfilling any obligation or performing any service under this Agreement if Employer or its designee does not provide accurate information in a timely manner.

3. **Reporting**. CHLIC shall make available to Employer CHLIC's standard reporting applications, subject to Applicable Law and Exhibit D, including, without limitation, HIPAA and state privacy laws.

4. **Claims Data**.

   (a) Retention. CHLIC shall retain data with respect to Claims for at least seven (7) years from the date the prescription is filled. Following the close of such retention period, CHLIC shall retain and dispose of such Claims data pursuant to its then-current standard policies and procedures, Applicable Law and the Business Associate Agreement described in the Agreement.

   (b) Disclosure to Vendor. Upon Employer's written request and subject to execution of a non-disclosure agreement acceptable to CHLIC, CHLIC shall provide prescription Claims data in its standard format to a vendor contracted with Employer and otherwise acceptable to CHLIC solely for the purposes of such vendor's support of Plan administration functions. Employer agrees that its vendors may not utilize Claims data for any other purpose, including, without limitation, developing products and services, analyzing the Claims data against market benchmarks or CHLIC competitors or adding to a normative database (even if de-identified and/or blinded as to Member and PBM/carrier) for the Employer's or vendor's commercial use. Employer shall be responsible for any use or disclosure of Claims data, or any services provided, by the vendor. Notwithstanding the foregoing, all audits of any pricing guarantees, Rebate-sharing obligations or Claims processing accuracy shall be conducted in accordance with the terms in this Agreement specifically relating to such audits.

   (c) De-Identified Data. During and after the term of this Agreement, CHLIC may use Claims, drug, and medical data that has been de-identified in accordance with HIPAA for research, provider evaluation, database maintenance, and other commercial purposes.

This provision shall survive termination or expiration of the Agreement.

5. **Claims Processing Audits**. Employer may, in accordance with the requirements set forth in Section 6 of the Agreement and at no additional charge while this Agreement is in effect, audit CHLIC's payment of Plan Benefits subject to the conditions set forth in Section 6 of the Agreement.

6. **Rebate Audits**. Employer may, to the extent specified below, in accordance with the following requirements, and at no additional charge while this Agreement is in effect, audit CHLIC's Rebate payments subject to the following conditions:

   (a) Employer shall designate with CHLIC's consent, such consent not to be unreasonably withheld, an independent, third party auditor to conduct the audit (the "Auditor").

   (b) The Auditor may audit records directly related to CHLIC's performance of its obligations hereunder regarding Rebates once in each 12-month period upon the following conditions: (1) Employer shall provide at least 45 days written notice to CHLIC; (2) the Auditor (including each auditor conducting the audit) shall be agreeable to Employer and CHLIC; (3) a mutually agreed upon nondisclosure/nonuse contract shall be executed by Employer, the Auditor and CHLIC; (4) the records to be audited shall be no more than two years old as of the date of the audit; (5) the scope of records to be audited shall be as mutually agreed upon by the Auditor and CHLIC as those which are necessary to determine compliance with the Rebate-sharing obligations under this Agreement; (6) the audit shall be conducted at a mutually acceptable time during regular business hours at CHLIC's office where such records are located; (7) records shall not be removed or photocopied without CHLIC's express written consent; (8) the Auditor shall provide its audit report to CHLIC and Employer at the same time; and (9) the Auditor may disclose the aggregate amount of Rebates due Employer but no other details of CHLIC's manufacturer contracts of which the Auditor is apprised, if any.

This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT - FUNDING AND PAYMENT OF CLAIMS; CHARGES

1. **Funding and Payment of Claims**. With respect to Pharmacy Benefits, (1) CHLIC may withdraw funds from the Bank Account for the purposes specified in Section 3 of the Agreement five times per month, and (2) any recovered overpayments shall be credited to Employer via a line item on its invoice, less the fee set forth on the Schedule of Financial Charges.

2. **Retroactive Member Changes and Terminations**. Notwithstanding anything in the Agreement to the contrary, Employer shall remain responsible for all charges and Bank Account Payments incurred or charged through the date CHLIC processed Employer's notice of a retroactive change or termination of a Member's enrollment in the Plan. Notwithstanding anything to the contrary in Section 4.c. of the Agreement, with respect to Pharmacy Benefits, CHLIC generally will implement eligibility updates received from Employer that adhere to CHLIC's standard electronic format as soon as reasonably practicable following receipt of such updates.

PHARMACY BENEFIT MANAGEMENT - FIDUCIARY ACKNOWLEDGMENTS
CHLIC offers pharmacy benefit management services for consideration by Employer and other entities. The general parameters of such services and the supporting systems have been developed by CHLIC as part of CHLIC's administration of its general business as a pharmacy benefit manager for entities that sponsor group health plans. The Parties have negotiated the terms of this Agreement in an arm's-length fashion. Except to the extent CHLIC conducts the final level of internal appeal as set forth in Section 2.c of the Agreement, the Parties assert that neither Party intends that CHLIC shall be a fiduciary with respect to Pharmacy Benefits for either ERISA (if applicable) or state law purposes, and neither Party shall name CHLIC as a "plan fiduciary" with respect to its management of Pharmacy Benefits. Employer acknowledges and agrees that CHLIC (i) does not have discretionary authority or control respecting management of the Pharmacy Benefits, and (ii) does not exercise any authority or control respecting management or disposition of the assets relating to Pharmacy Benefits or of Employer. Rather, Employer retains all such authority and control. The Parties agree that, upon reasonable notice, CHLIC shall have the right to terminate its Pharmacy Benefit services under this Agreement to any Plan and/or Members located in a state that requires a pharmacy benefit manager to be a fiduciary to Employer, the Plan or a Member. This provision shall survive termination or expiration of the Agreement.
PHARMACY BENEFIT MANAGEMENT - FINANCIAL ARRANGEMENTS
1. **General**. CHLIC directly or indirectly contracts on its own account with Retail Pharmacies and Cigna Home Delivery Pharmacy to dispense covered pharmaceutical products to Employer's Members, and not on behalf of, or for the benefit of, Employer or the Plan; accordingly, any discounts or other remuneration CHLIC earns under an arrangement with a Retail Pharmacy or Cigna Home Delivery Pharmacy are obtained for, and inure to, the sole and exclusive benefit of CHLIC, and not the Employer or the Plan. Amounts paid to the Retail Pharmacy or Cigna Home Delivery Pharmacy for Brand Drug, Generic Drug, or Specialty Drug Claims may or may not be equal to the amount charged to Employer and/or Member. If the amount paid by Employer and/or Member does not equal the amount paid by CHLIC to a particular pharmacy, CHLIC will absorb or retain such difference. CHLIC directly or indirectly contracts with pharmaceutical manufacturers for Rebates, Manufacturer Administrative Fees, and other remuneration on its own behalf and for its own benefit, and not on behalf of Employer or the Plan. As an example of other remuneration other than Rebates or Manufacturer Administrative Fees that CHLIC may earn, CHLIC may also directly or indirectly earn from pharmaceutical manufacturers remuneration in connection with value payments and/or services that CHLIC provides to Employer ("Value-Based Payments"). Notwithstanding anything in this Agreement to the contrary, any Value-Based Payments earned by CHLIC are separate and apart from any Rebates or Manufacturer Administrative Fees that CHLIC directly or indirectly earns from pharmaceutical manufacturers, and CHLIC may retain any Value-Based Payments it earns. As examples of the value payments and/or services that CHLIC may provide to Employer in connection with Value-Based Payments that CHLIC may earn, CHLIC may provide care management or related services to Employer and/or remit to Employer monetary credits if Members discontinue therapy on certain pharmaceutical products. Information regarding

any services, and/or monetary credits or other financial value, for which Employer may be eligible with respect to specific pharmaceutical products or therapeutic classes/conditions, including the products for which monetary credits or other financial value may be available to Employer, the amount of that value, and other payment terms, is available upon request. Any value payments and/or services provided by CHLIC to Employer are subject to change or termination by CHLIC as the value program(s), if any, offered by CHLIC change(s) or terminate(s). Accordingly, CHLIC retains all right, title and interest to any and all actual Rebates, Manufacturer Administrative Fees, Value-Based Payments, and other remuneration received from manufacturers. CHLIC will pay Employer amounts equal to all or some portion of the Rebate and Manufacturer Administrative Fee amounts, or other financial value generated in connection with any value program(s), allocated to Employer, if any, and as specified on the Schedule of Financial Charges, from CHLIC's general assets (neither Employer, its Members, nor Employer's Plan retains any beneficial or proprietary interest in CHLIC's general assets). Rebate and Manufacturer Administrative Fee amounts received vary based on factors including, without limitation, Employer-specific utilization, the volume of utilization as well as Formulary position applicable to the drug or supplies, and adherence to various formulary management controls, benefit design requirements, and Claims volume. Employer acknowledges and agrees that neither it, its Members nor its Plan will have a right to interest on, or the time value of, any Claim payments charged by CHLIC to Employer or any Rebate, Manufacturer Administrative Fee or other payments received by CHLIC during the collection period of moneys payable under this section, if any, and that CHLIC shall retain any such remuneration.

2. **Affiliates**. Cigna Home Delivery Pharmacy may maintain product purchase discount arrangements and/or fee-for-service arrangements with pharmaceutical manufacturers and wholesale distributors in its capacity as a mail service and/or specialty pharmacy. Cigna Home Delivery Pharmacy may contract for these arrangements on its own account in support of its pharmacy operations, and not on behalf of, or for the benefit of, Employer or the Plan. Accordingly, Cigna Home Delivery Pharmacy retains the sole and exclusive benefit of any difference between its acquisition cost for a pharmaceutical product and the amount charged to Employer under this Agreement. Further these arrangements relate to services provided outside of this Agreement and other pharmacy benefit management arrangements and may be entered into without regard to whether a specific drug is on one of the formularies that CHLIC offers to entities that sponsor group health plans. Discounts and fee-for-service payments received by Cigna Home Delivery Pharmacy are not part of the pharmacy benefit management formulary rebates or associated administrative fees or charges paid to CHLIC in connection with CHLIC's pharmacy benefit management formulary rebate programs.

This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT - OBLIGATIONS UPON TERMINATION

Upon notice of termination of this Agreement, the following provisions shall apply with respect to Pharmacy Benefits:

a) Employer shall notify Members at least thirty (30) days prior to the termination of the Agreement becoming effective of any transition to a successor pharmacy benefit manager.

b) If mutually agreed upon by CHLIC and Employer, CHLIC shall provide services following termination of the Agreement at CHLIC's then-prevailing rate. Such services, if any, shall be determined by mutual agreement of CHLIC and Employer in advance of the termination of the Agreement becoming effective.

c) Upon request by Employer and subject to execution of a nondisclosure agreement acceptable to CHLIC, CHLIC shall transition Claims files and/or history to the pharmacy benefit manager or other third party specified by Employer and otherwise acceptable to CHLIC. Any disclosure of Claims files and/or history shall be limited to the information the successor pharmacy benefit manager or other third party needs to implement or administer Employer's pharmacy benefits. CHLIC shall not be required to directly or indirectly release, and Employer shall not release, PBM Proprietary Information to any such third party.

d) Upon termination of the Agreement for any reason, the Parties shall handle Confidential Information, PBM Proprietary Information and Protected Health Information (as defined in the Business Associate Agreement attached as Exhibit D) pursuant to the terms of the Agreement.

e) In the event that CHLIC terminates the Agreement pursuant to Section 1.v of the Agreement, CHLIC shall have no further obligation following the date of such termination to pay Employer any Rebates, or any other amount that may otherwise be payable by CHLIC to Employer.

This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT - CONFIDENTIALITY

1. **General**. Employer acknowledges and agrees that CHLIC's PBM Proprietary Information constitutes competitively sensitive trade secrets, and that its misuse or mis-disclosure could result in material financial and legal loss or liability to CHLIC, its affiliates and their respective subcontractors. CHLIC shall not be required to disclose PBM Proprietary Information to Employer except to the extent necessary for Employer to exercise any audit rights expressly provided hereunder or perform other Plan administration functions. If CHLIC discloses PBM Proprietary Information to Employer, or, if CHLIC consents, to the Employer's vendor or designee, CHLIC may require Employer, or its vendor or designee, to execute a non-disclosure agreement specifically relating to the requested PBM Proprietary Information. Employer agrees that it and its vendors may not utilize PBM Proprietary Information for any purpose other than performing Plan administration functions, including, without limitation, developing products and services, de-identifying, blinding or analyzing the PBM Proprietary Information against market benchmarks or CHLIC competitors or adding to a normative database for the Employer's, or vendor's or designee's, commercial use. For the purposes of clarity, information shall not cease to qualify as PBM Proprietary Information if Employer or its vendor or designee de-identifies and/or blinds the PBM Proprietary Information such that the information cannot be traced or identified to a Member or CHLIC, its affiliates or their respective subcontractors. Employer shall be solely responsible for any disclosure of PBM Proprietary Information by CHLIC to Employer or its vendor or designee, or any subsequent use or disclosure by Employer or its vendor or designee, or services provided by the same. Notwithstanding anything herein to the contrary, in no event will CHLIC be required to disclose to Employer, or its vendor or designee, information related to, or including, its pharmacy network agreements, vendor agreements or pharmaceutical manufacturer agreements.

2. **Compelled Disclosures**. If at any time Employer, or its vendor or designee, is required by law, court order or other valid legal process to disclose any Confidential Information, it will promptly notify CHLIC prior to any such compelled disclosure and, upon request, cooperate with CHLIC in seeking a protective order or other available relief to contest or limit the scope of such compelled disclosure.

3. **Return or Destruction of Information**. At any time upon CHLIC's request or upon expiration or termination of this Appendix A or the Agreement, whichever occurs first, Employer will, at CHLIC's option, promptly deliver, or, as the case may be, compel its vendor or designee to deliver, to CHLIC all PBM Proprietary Information or other Confidential Information (or such portion thereof as requested) and not retain any copies in whole or in part of such PBM Proprietary Information or other Confidential Information, or securely destroy or dispose, or, as the case may be, compel its vendor or designee to destroy or dispose, of those portions of documents and other materials in any form, including electronic form, prepared by or received by the Employer or its vendor or designee, that contain or reflect such PBM Proprietary Information or other Confidential Information. Employer, or its vendor or designee, shall certify such return and destruction, as the case may be, to CHLIC.

Appendix B - Cigna Home Delivery Pharmacy Specialty Drug List

THIS SPECIALTY DRUG LIST IS CONFIDENTIAL, PROPRIETARY INFORMATION OF CHLIC. IT IS PROVIDED SOLELY FOR EMPLOYER'S PLAN ADMINISTRATION PURPOSES. RE-DISCLOSURE IS STRICTLY PROHIBITED EXCEPT AS OTHERWISE PROVIDED BY APPLICABLE LAW. CHLIC RESERVES ALL LEGAL RIGHTS AND REMEDIES TO ENFORCE THESE PROHIBITIONS ON USE AND DISCLOSURE.

The Specialty Drug List shall be provided separately to Employer, and is hereby incorporated into the Agreement by reference, inclusive of any changes made subsequent to CHLIC's initial issuance of the Specialty Drug List to Employer to the pharmaceutical products included on the Specialty Drug List or the discounts pertaining to such pharmaceutical products. Upon Employer's request on or after the Effective Date, CHLIC shall provide to Employer an updated Specialty Drug List.

Currently Marketed Specialty Drugs on this Specialty Drug List. The discounts in this Specialty Drug List are the discounts that will be adjudicated in CHLIC's claim processing system for the drug indicated when dispensed by Cigna Home Delivery Pharmacy, subject to all of the following.

- Any or all of the discounts in this Specialty Drug List may be adjusted by CHLIC to the extent reasonably necessary to preserve the economic value of this Agreement as it existed immediately prior to the occurrence of any of the following events: a major change in market conditions affecting the pharmaceutical or pharmacy benefit management market, a drug shortage in the market, an issue involving the safety of the drug supply, or similar market situation.

- The discounts in this Specialty Drug List are based on the terms and design of the Pharmacy Benefit that Employer has adopted and disclosed to CHLIC. Accordingly, if Employer fails to disclose to CHLIC, for example, that it uses or intends to use a consumer-driven health plan, a major cost-sharing program, or a utilization management program promoting generic or OTC drugs over brand drugs, CHLIC may adjust the discounts as it reasonably deems necessary to preserve the economic value or benefit of this Agreement as CHLIC anticipated based on the terms and design of the Pharmacy Benefit previously disclosed to CHLIC and prior to CHLIC's discovery of the Pharmacy Benefit design feature that materially impacts CHLIC's discounts in this Specialty Drug List.

- The discounts in this Specialty Drug List shall not apply to Compound Drug claims, Claims that process at U&C, and direct member reimbursement (DMR) Claims.

- Any or all of the discounts in this Specialty Drug List may be adjusted by CHLIC to the extent reasonably necessary to preserve the economic value of this Agreement as it existed immediately prior to the occurrence of any of the following events: (a) there are any significant changes in the composition of CHLIC's pharmacy network or in CHLIC's pharmacy network contract compensation rates, or the structure of the pharmacy stores/chains/vendors that are contracted with CHLIC, including but not limited to disruption in the retail pharmacy delivery model, or bankruptcy of a chain pharmacy; or (b) there is a change in government laws or regulations which has a significant impact on pharmacy claim costs; or (c) any material manufacturer-rebate contracts with or for the benefit of CHLIC are terminated or modified in whole or in part; or (d) there is any legal action or Law that materially affects or could materially affect the manner in which CHLIC's rebate program is administered or an existing Law is interpreted so as to materially affect or potentially have a material effect on CHLIC's administration of the Pharmacy Benefit; or (e) there is a material

change in the Plan or the Plan's Pharmacy Benefit that is initiated by Employer which impacts CHLIC's costs.

New-to-Market Specialty Products. Specialty Drug Claims that are for new-to-market drugs will have a minimum market-introduction guaranteed discount of 11.45% off the drug's AWP.

IN WITNESS WHEREOF, the parties have executed this Administrative Services Only Agreement "Amendment" on the date set forth below.

CITY OF SANTA FE:

_____

ALAN WEBBER, MAYOR

DATE:_____

CONTRACTOR:
CIGNA

_____

NAME & TITLE

DATE:_____

ATTEST:

_____

YOLANDA Y. VIGIL, CITY CLERK

CITY ATTORNEY'S OFFICE:

MDM 4/16/20

SENIOR ASSISTANT CITY ATTORNEY

APPROVED FOR FINANCES:

_____

MARY MCCOY, FINANCE DIRECTOR

Business Unit Line Item

CITY OF SANTA FE PROCUREMENT CHECKLIST

Contractor Name: Cigna Health and Life Insurance
Procurement Title: Request for Approval of Amendment 6 to 15-0757

Procurement Method: State Price Agreement ☐ *Cooperative* ☐ *Sole Source* ☐ *Other* ☐ _____

Exempt ☐ *Request For Proposal* (RFP) ☒ *Invitation To Bid (ITB)* ☐ *Contract under 60K* ☐ *Contract over 60K* ■

Department Requesting: Human Resources Staff Name: Bernadette Salazar

Procurement Requirements:
A procurement file shall be maintained for all contracts, regardless of the method of procurement. The procurement file shall contain the basis on which the award is made, all submitted bids, all evaluation materials, score sheets, quotations and all other documentation related to or prepared in conjunction with evaluation, negotiation, and the award process. The procurement shall contain a written determination from the Requesting Department, signed by the purchasing officer, setting forth the reasoning for the contract award decision before submitting to the Committees. .

REQUIRED DOCUMENTS FOR APPROVAL BY PURCHASING*

YES	N/A	
☒	☐	Approved Procurement Checklist (by Purchasing)
☒	☐	Memo addressed to City Manager (under 60K) Committees/City Council (over 60K)
☐	☒	State Price Agreement
☒	☐	RFP
☐	☒	Evaluation Committee Report
☐	☒	ITB
☐	☒	Bib Tab
☐	☒	Quotes (3 valid current quotes)
☐	☒	Cooperative Agreement
☐	☒	Sole Source Request and Determination Form
☐	☒	Contractors Exempt Letter
☒	☐	Purchasing Officers approval for exempt procurement
☐	☒	BAR
☐	☒	FIR
☒	☐	Executed Contract, Agreement or Amendment
☒	☐	Current Business Registration and CRS numbers on contract or agreement
☒	☐	Summary of Contracts and Agreements form
☒	☐	Certificate of Insurance
☐	☐	All documentation presented to Committees
☒	☐	Other: RFP 15/24/P

Alvin Valdez		11/14/2022
Department Rep Printed Name (attesting that all information included)	Title	Date
	Contracts Supervisor	Nov 16, 2022
Purchasing Officer (attesting that all information is reviewed)	Title	Date

Include all other substantive documents and records of communication that pertain to the procurement and any resulting contract.

*

City of Santa Fe

Real Estate Summary of Contracts, Agreements, Amendments & Leases

Section to be completed by department

1. Munis Contract # 3200119

Contractor: Cigna Helath and Life Insurance

Description:

Contract ☐ Agreement ☐ Lease / Rent ☐ Amendment ☒

Term Start Date: July, 1 2023 Term End Date: 06/30/2025

☒ Approved by Council Date: 11/14/2022

Contract / Lease: Administration of Self-Insured Health & Life Benefit Plans on behalf of the City of SF

Amendment # 6 to the Original Contract / Lease # 15-0757

Increase/(Decrease) Amount $ Current fixed costs will remain flat and fees guaranteed until 6/30/2025. Pharmacy pricing improves. ISL contingent on Claims.

Extend Termination Date to: 06/30/2025

☐ Approved by Council Date:

Amendment is for: Extend the Term, Fixed Costs Remain Flat for Duration of Contract, Pharmacy Pricin

2. **HISTORY of Contract, Amendments & Lease / Rent - Please Elaborate** (option: attach spreadsheet if multiple amendments)

Original Contract was for 07/01/2015 to 06/30/2019
Amendment No. 1 7/1/2016, increase compensation
Amendment No. 2 7/1/2017, increase compensation
Amendment No. 3 7/1/2018, increase compensation
Amendment No. 4 7/1/2019, extend term of contract to 6/30/2020 & increase compensation
Amendment No. 5 7/1/2020, extend term of contract to 6/30/2023 & increase compensation

3. **Procurement History:** RFP 15/24/P. 2/23/2015

Purchasing Officer Review: 11/14/2022 Date:

Comment & Exceptions: General Service Contract extended to 10 years total & increase comp

4. **Funding Source:** 605 SF Health and Dental Fund **Org / Object:** 6050237.510300, 6050238

Andy Hopkins 11/14/2022

Budget Officer Approval: Date: 11/14/2022

Comment & Exceptions:

Staff Contact who completed this form: Alvin Valdez Phone # 505-955-6075

Email: aavaldez1@santafenm.gov

To be recorded by City Clerk:
Clerk #
Date of Execution:

ITT Representative (attesting that all information is reviewed) Title Date

MEMORANDUM

Date: November 28, 2022

To: Alan Webber, Mayor
City Council

Via: John Blair, City Manager
Bernadette Salazar, Human Resources Director

From: Alvin Valdez, Benefits and Wellness Supervisor

Re: Request for the Approval of Amendment No. 6 to Extend the Term of the Administrative Services Agreement #15 for City of Santa Fe Employer Sponsored Health and Life Insurance Benefits; Cigna Health and Life Insurance Company. Bernadette Salazar, Human Resources Director, bjsalazar@santafenm.gov, (505) 955-6591

Background:

The City and Cigna Health and Life Insurance entered into an agreement effective July 1, 2015 to offer employer sponsored health and life insurance benefits to benefit-eligible City personnel.

The City selected Cigna Health and Life Insurance through a competitive RFP process in 2015 where Cigna provides Medical, Dental, Vision, Life Insurance, Administrative Services and Stop Loss Coverage. We are requesting to extend and modify the Administrative Services Agreement (#15-0757) for two (2) additional years, concluding on June 30, 2025, as City Attorney's Office and Procurement staff concluded that the Cigna contract could be extended up to 10 years as provided in Statue: 13-1-150.

The language in the Procurement Code which allows a general service contract to be extended up to 10-years including all renewals is found under NMSA 1978 § 13-1-150;

"If the amount of the contract is twenty-five thousand dollars ($25,000) or more, the term shall not exceed ten years, including all extensions and renewals, except that for a contract entered into pursuant to the Public Facility Energy Efficiency and Water Conservation Act, the term shall not exceed twenty-five years, including all extensions and renewals. Payment and performance obligations for succeeding fiscal periods shall be subject to the availability and appropriation of funds therefor."

The current fixed costs will remain flat for the duration of the next two years and the fees are guaranteed through June 30, 2025. The pharmacy contract maintains current pricing. Benefits

that are dependent on claims, (stop loss insurance and renewal rates) will be presented to the Governing Body consistent with each budget cycle during the FY24 budget process at the annual budget hearings.

The cost of the administrative fees for the duration of the 2 Year contract extension are shown in the table below:

Medical -Administrative Fee Renewal

	Current Enrollme	2022-2023	2023-2024	2024-2025
Medical		Self-Funded	Self-Funded	Self-Funded
Admin Fees Per Employee Per Month (PEPM)	PEPM	$17.81	$17.81	$17.81
Network Access-HMCM, , One Guide	PEPM	$25.11	$25.11	$25.11
Other Medical Fees				
HRA Fee	PEPM	$5.34	$5.34	$5.34
FSA Fee	PEPM	$5.79	$5.79	$5.79

Dental-Administrative Fee Renewal

	Current Enrollmei	2022-2023	2023-2024	2024-2025
Dental Type		Self-Funded	Self-Funded	Self-Funded
Admin Fees	PEPM	$2.93	$2.93	$2.93
Network Access	PEPM	$0.90	$0.90	$0.90

Vision Renewal

	Current Enrollmei	2022-2023	2023-2024	2024-2025
Employee	PEPM	$8.00	$8.00	$8.00
Employee + Spouse	PEPM	$16.01	$16.01	$16.01
Employee + Child(ren)	PEPM	$16.17	$16.17	$16.17
Employee +Family	PEPM	$25.80	$25.80	$25.80

Action Requested:

Through this memo, I respectfully request that Amendment No. 6 to the Agreement be approved. Thank you for your consideration.

Attachment(s):

Appendix

Cigna Health and Life Insurance ASO Agreement #15-0757

Cigna Health and Life Insurance ASO Agreement Amendment No. 1

Cigna Health and Life Insurance ASO Agreement Amendment No. 2

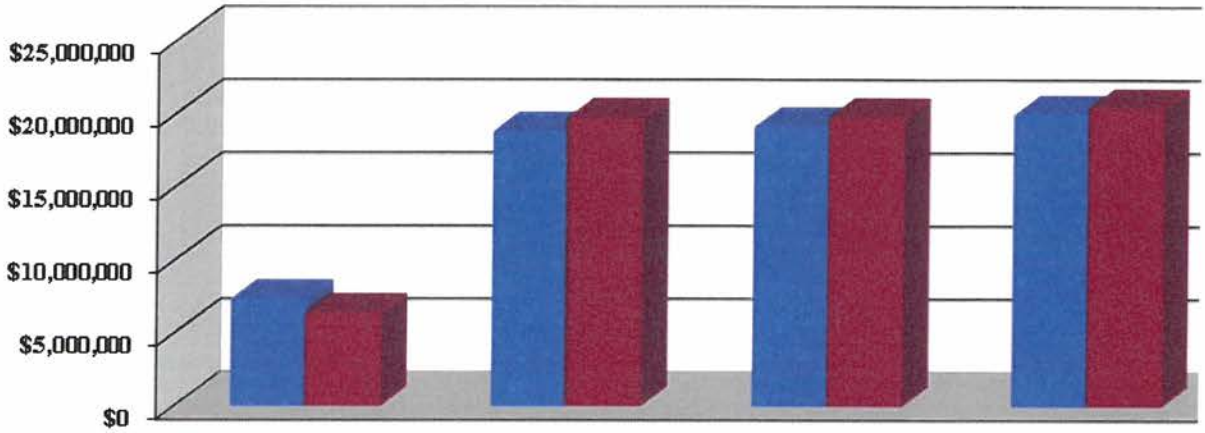
Cigna Health and Life Insurance ASO Agreement Amendment No. 3

Cigna Health and Life Insurance ASO Agreement Amendment No. 4

Cigna Health and Life Insurance ASO Agreement Amendment No. 5

APPENDIX

City of Santa Fe
Medical Plan Performance



CARRIER	Cigna			
PLAN	COMBINED			
YEAR	7/22-10/22	7/21-6/22	7/20-6/21	7/19-6/20
Average Contracts	1,101	1,072	1,122	1,184
% Variance to Prior Year	2.7%	-4.4%	-5.2%	-1.6%
Average Members	2,521	2,477	2,614	2,769
% Variance to Prior Year	1.8%	-5.3%	-5.6%	-2.8%
Average Contract Size	2.29	2.31	2.33	2.34
UTILIZATION				
CoSF Funding Level	$7,261,206	$18,731,182	$19,065,707	$19,913,557
CoSF Funding Level PMPM	$720.07	$630.21	$607.73	$599.34
% Variance to Prior Year	14.3%	3.7%	1.4%	8.7%
Claims (net of SL recoveries)	$5,547,940	$17,663,754	$17,828,634	$18,474,956
Fixed Costs	$758,781	$2,000,549	$1,873,382	$1,870,656
Total Claims+Fixed Costs	$6,306,720	$19,664,303	$19,702,016	$20,345,613
Surplus / Deficit	$954,486	($933,121)	($636,309)	($432,055)
TOTAL PMPM	$625.42	$661.61	$628.01	$612.34
% Variance to Prior Year PMPM	-5.5%	5.3%	2.6%	3.5%
COMPARE TO FUNDING	86.9%	105.0%	103.3%	102.2%

Aimee E. Burnham
Contractual Agreement Unit Manager
Cigna

Routing W122A
900 Cottage Grove Road
Hartford, CT 06152
Telephone 860.226.4422
Facsimile 860.730.3944
Aimee.Burnham@cigna.com

October 21, 2022

Alvin Valdez
Wellness & Benefits Supervisor
City of Santa Fe
200 Lincoln Ave
Santa Fe, New Mexico 87501

RE: Administrative Services Only Account No. 3338881

Dear Alvin Valdez:

This letter will serve as an amendment to the Administrative Services Only Agreement between Cigna Health and Life Insurance Company ("**CHLIC**") and City of Santa Fe ("**Employer**"), effective July 1, 2015, (the "**Agreement**") and as amended on July 1, 2016, July 1, 2017, July 1, 2020, and July 1, 2022. And supplemented by the disclosure letters effective July 1, 2018 and July 1, 2021

Effective as of July 1, 2023, 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.

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

Agreement means this entire document including the Schedule of Financial Charges and all Exhibits and Addenda, as attached hereto, as well as any subsequent amendments.

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

v. Notwithstanding the foregoing, all provisions in this Agreement reasonably related to CHLIC's administration of the Plan's Pharmacy Benefit (as such term is defined in Appendix A) (the "Pharmacy Benefit Provisions"), shall continue in effect for no less than twenty four (24) months commencing on July 1, 2023, except that, if any of the following dates occurs, the Pharmacy Benefit Provisions set forth in the Schedule of Financial Charges and Appendix A will cease being in effect as of such date:

   a. The effective date of any Applicable Law or governmental action which prohibits performance of the activities in connection with the Pharmacy Benefit required by this Agreement;

   b. The date upon which Employer fails to fund the Bank Account as required by this Agreement for claims under the Pharmacy Benefit provided CHLIC notifies Employer of its election to terminate the Pharmacy Benefit Provisions;

   c. The date upon which Employer fails to pay CHLIC any charges in connection with the Pharmacy Benefit identified in this Agreement when due, provided CHLIC notifies Employer of its election to terminate the Pharmacy Benefit Provisions; or

   d. The date that is sixty (60) days after written notice by either Employer or CHLIC ("non-defaulting party") of the material breach by the other (the "defaulting party") of a material

obligation of the defaulting party related to the Pharmacy Benefit (other than failure to fund the Bank Account or failure to pay any charges when due pursuant to Sections 1.vi.b and 1.vi.c above) that is not cured to the reasonable satisfaction of the non-defaulting party within a reasonable time following the initial notice of breach.

During such twenty four (24) month period (or shorter period, as applicable under (a), (b), (c) or (d) above), CHLIC will continue to be the exclusive provider of Pharmacy Benefit administration services for the Plan's Pharmacy Benefit.

In the event that Employer purports to terminate such arrangement or enters into an agreement with another pharmacy benefit manager ("PBM") or other third party to provide any or all pharmacy benefit management services for Employer's benefit plan prior to the end of such twenty four (24) month period, then, within thirty (30) days of CHLIC's written request, Employer shall pay CHLIC the amount of $1.50 per the average monthly number of Members who were enrolled in the Plan's Pharmacy Benefit from the beginning of the twenty four (24) month period to the effective date of such purported termination or other agreement multiplied by the number of months remaining until the end of the twenty four (24) month period. However, if Employer terminates its CHLIC medical coverage under this Agreement, no such fee shall apply.

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

b. Following (i) termination of this Agreement, except pursuant to Section 1.iii; (ii) termination of a Plan benefit option or (iii) termination of eligible Members, if any required fees have been paid in full, CHLIC shall process Run-Out Claims for the applicable Run-Out Period (Refer to Schedule of Financial Charges for applicable fees and Run-Out Period). At the termination of any applicable Run-Out Period, CHLIC shall cease processing Run-Out Claims and, subject to the requirements of Section 21.a, make all relevant records in its possession relating to such claims, other than CHLIC's proprietary information, reasonably available to Employer or Employer's designee. CHLIC is not required to provide proprietary information to Employer or any other party.

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

Section 9. Modification of Agreement

Except as otherwise provided for in this Agreement, no modification or amendment hereto shall be valid unless in writing and agreed to by an authorized person of each of the Parties. The charges identified in this Agreement may be revised in accordance with Section 8by CHLIC providing written notice to Employer and Employer indicating its acceptance of the modification either by paying the revised charges or failing to object to such revised charges in writing to CHLIC within fifteen (15) business days of receipt of such notice from CHLIC. The revised charges will be effective on the date indicated in CHLIC's written notice to Employer unless otherwise agreed to by CHLIC and Employer.

Section 12.d of the Administrative Services Only Agreement is hereby amended in its entirety as follows:

d. The Parties intend the dispute resolution procedure described above to be a private undertaking. The Parties agree that an arbitration conducted under this provision will not be consolidated with an arbitration involving third parties not parties to this Agreement, including other plans administered in whole or in part by CHLIC or other affiliates of Cigna Corporation. The arbitrator will be without power to conduct arbitration on a class or representative basis. The Parties waive their rights to

participate in a class action or representative proceeding regarding the Controversy that would otherwise be resolved through the process outlined in this Section 12. The arbitrator may award declaratory or injunctive relief only in favor of the individual Party seeking relief and only to the extent necessary to provide relief warranted by that Party's individual claim. All disputed issues in a Controversy are for the arbitrator to decide, except the courts will decide those issues relating to the scope and enforceability of the arbitration provision.

Section 14, "Waivers," of the Administrative Services Only Agreement is hereby replaced in its entirety with Section 14, "No Waivers," as follows:

Section 14. No Waivers

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

Section 20, "Identifying Information and Internet Usage," of the Administrative Services Only Agreement is hereby replaced in its entirety with Section 20, "Identifying Information, Internet Usage, and Trademark," as follows:

Section 20. Identifying Information, Internet Usage and Trademark

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

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

Section 21, "Confidentiality," is hereby added to the Administrative Services Only Agreement as follows:

Section 21. Confidentiality

a. Subject to the requirements of Applicable Law, the terms of this Agreement and the Privacy Addendum in Exhibit D, a signed Business Associate Agreement between Employer and its designee(s), and a signed Confidentiality Agreement between CHLIC and applicable designee(s), CHLIC shall release copies of confidential claims and Plan Benefit payment information in CHLIC's claims system ("**Confidential Information**") and may release copies of proprietary information relating to the Plan in CHLIC's claims system ("**Proprietary Information**") to the Employer and/or its designee(s). Employer will keep Confidential Information and Proprietary Information confidential and will use Confidential Information and Proprietary Information solely for the purpose of administering the Plan or as otherwise required by law. Employer is solely responsible for any unauthorized use or disclosure of Confidential Information and/or Proprietary Information provided by CHLIC pursuant to this Section 21 whether by Employer or its designee and the consequences thereof.

b. CHLIC and any of its affiliates or subsidiaries which have any Protected Health Information in their possession will maintain the confidentiality of such Protected Health Information in accordance with the Privacy Addendum in Exhibit D and any applicable state privacy laws, including, without limitation, 201 CMR 17.00: Massachusetts Standards for the Protection of Personal Information of Residents of the Commonwealth.

c. Upon termination of this Agreement and subject to the provisions of Section 21.a above, CHLIC shall make information available to a third party such as a "successor administrator" as requested by Employer, to the extent administratively feasible, if the Parties agree upon the charge to be paid by Employer.

The obligations set forth in this Section 21, shall survive termination of this Agreement.

Section 22, "Independent Contractors," is hereby added to the Administrative Services Only Agreement as follows:

Section 22. Independent Contractors

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

Section 23, "Reservation of Intellectual Property Rights," is hereby added to the Administrative Services Only Agreement as follows:

Section 23. Reservation of Intellectual Property Rights

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

The obligations set forth in this Section 23 shall survive termination of this Agreement.

Section 24, "Entire Agreement," is hereby added to the Administrative Services Only Agreement as follows:

Section 24. Entire Agreement

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

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

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

The terms of the Administrative Services Only Agreement identified above, as mentioned herein, will be effective as of July 1, 2023. Please indicate your agreement to the amendment by signing the enclosed copy of this letter where indicated and returning it to me. Alternatively, this amendment shall become effective on the effective date indicated unless Employer notifies CHLIC either electronically or in writing (at the address indicated above) within sixty (60) days of the date of this letter that it does not accept all the terms of this amendment notwithstanding any provision to the contrary in the Administrative Services Only Agreement. In that case, CHLIC shall cooperate to negotiate mutually agreeable terms with Employer. Once agreement with respect to the terms of the amendment is reached, the amendment will apply retroactively to the effective date.

Sincerely,

Aimee E. Burnham

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

Accepted by: **CITY OF SANTA FE**

By: _____

Name: _____

Title: _____

Executed this ____ day of _____, in the year _____

Schedule of Financial Charges

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

	MEDICAL/DENTAL ADMINISTRATION CHARGES	
Product	**Description**	**Charge**
Medical	HRA Open Access Plus (OAP) with Care Management Preferred (All Plans)	**$48.26/employee/month**
Medical	Open Access Plus (OAP) with Care Management Preferred (All Plans)	**$42.92/employee/month**
Dental	Dental Preferred Provider Organization (DPPO)	**$3.83/employee/month**
	MEDICAL/DENTAL NETWORK ACCESS FEE, UTILIZATION MANAGEMENT FEE AND OPTIONAL PROGRAM FEE	
Product	**Description**	**Charge**
Medical	HRA OAP Access Fee (All Plans)	**$25.11/employee/month Included in Medical Administration Charge**
Medical	OAP Access Fee (All Plans)	**$25.11/employee/month Included in Medical Administration Charge**
Dental	DPPO Access Fee	**$0.90/employee/month Included in Dental Administration Charge**
	MULTI-YEAR CHARGE/FEE GUARANTEES	
	The maximum increase for the Medical Administration Charge(s) and Network Access Fee(s) for the 2024 Plan Year will be 0.00% over the 2023 Plan Year charges/fees. The above fee guarantees are not applicable to Pharmacy Administration Fee. The above charges/fees are guaranteed for the time periods identified above, provided, however, that CHLIC may revise the above charges/fees pursuant to Section 8 of this Agreement.	

	CIGNA CHOICE FUND AND OTHER CONSUMER DIRECTED ACCOUNT ADMINISTRATION SERVICES AND CHARGES	
	Product	**Charge**
	Cigna Choice Fund Health Reimbursement Account (HRA) Administration	**For HRA OAP Products: $5.34/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. • Education and referral coaching on program topics with referral to appropriate internal and external resources available. • Access to educational materials and web based Member tools and resources. • Identification of gaps in care and outreach to Member to provide coaching for those identified with gaps for high cholesterol, high blood pressure, and additional coaching on other gaps in care will also occur. • Support of Participants identified through predictive modeling with certain preference sensitive care conditions by supplying impartial evidence based medical information, to empower Participants to understand the potential benefits/ disadvantages of a specific course of action and make more informed care decisions. • Answering health and medical related questions. • Counseling Participants on prevention and the benefits of compliance with prescribed medications and treatments.	**For HRA OAP Only: Included in Medical Access Fee**

	Dependent Care Flexible Spending Account (DFSA) Administration	**For DFSA Products: Included at No Additional Cost**
	Health Care Flexible Spending Account (FSA) Administration	**For FSA Products: $5.79/employee/month**

AMOUNTS OWED TO CHLIC

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

CIGNA PHARMACY BENEFIT MANAGEMENT SERVICES CHARGES AND RELATED PROVISIONS

PHARMACY ADMINISTRATION FEE

Cigna Pharmacy Product Administration Fee, only if applicable, is separate from the Medical Administration Charge shown above, but included on same billing line as the Medical Administration Charge for billing purposes only.

CHARGES FOR COVERED DRUGS

Drugs Dispensed by Cigna Home Delivery Pharmacy: CHLIC will charge Employer for Covered Drugs dispensed to Members by Cigna Home Delivery Pharmacy based on the following charges, subject to the "PBM Pricing – Additional Provisions" section:

Brand Drug Claims: AWP minus an Actuarially Estimated average discount of 24.00%.

Generic Drug Claims: AWP minus an Actuarially Estimated average discount of 86.20%.

Specialty Drug Claims: The Specialty Drug's charge discounted as shown in the Cigna Home Delivery Pharmacy Specialty Drug List, attached as Appendix B hereto.

Dispensing Fees for Both Brand Drug Claims and Generic Drug Claims: An average Dispensing Fee of no more than $0.00.

Covered Drugs Dispensed by Retail Pharmacies in 30-day* supplies: CHLIC will charge Employer for 30-day supplies of Covered Drugs dispensed by a Retail Pharmacy based on the following charges, subject to the "PBM Pricing – Additional Provisions" section:

***A 30-day supply means any Covered Drug dispensed by a Retail Pharmacy in an amount less than an 83-day supply.**

Brand Drug Claims: The lesser of (i) AWP minus an Actuarially Estimated average discount of 19.30%; or (ii) the Retail Pharmacy's U&C Charge.

Generic Drug Claims: AWP minus an average discount of 82.50%.

Dispensing Fees for Both Brand Drug Claims and Generic Drug Claims: An Actuarially Estimated average Dispensing Fee of no more than $0.85, except in the case of Claims adjudicated at the U&C Charge, for which no separate Dispensing Fee is charged.

Covered Drugs Dispensed by Retail Pharmacies in 90-day supplies:** CHLIC will charge Employer for 90-day supplies of Covered Drugs dispensed by a Retail Pharmacy based on the following charges, subject to the "PBM Pricing – Additional Provisions" section:

****A 90-day supply means any Covered Drug dispensed by a Retail Pharmacy in an amount equal to or greater than an 83-day supply.**

Brand Drug Claims: The lesser of (i) AWP minus an Actuarially Estimated average discount of 23.50%%; or (ii) the Retail Pharmacy's U&C Charge.

Generic Drug Claims: AWP minus an average discount of 85.20%.

Dispensing Fees for Both Brand Drug Claims and Generic Drug Claims: An average Dispensing Fee of no more than $0.00, except in the case of Claims adjudicated at the U&C Charge, for which no separate Dispensing Fee is charged.

AGGREGATE SPECIALTY DRUG DISCOUNT

For covered Specialty Drug prescriptions dispensed by a Retail Pharmacy and a Cigna Home Delivery Pharmacy, CHLIC will charge Employer an Actuarially Estimated annual average AWP discount of 18.53%.

PBM PRICING – ADDITIONAL PROVISIONS

- The amount paid by CHLIC to the Retail Pharmacy for Claims for Covered Drugs may or may not be equal to the amount charged to Employer and/or Member, and CHLIC will absorb or retain any difference.
- For a specific Claim for a Covered Drug dispensed by a Retail Pharmacy or Cigna Home Delivery Pharmacy, and after application of any Plan cost-share requirements, CHLIC shall charge the Employer the lowest of the following amounts:
  - (1) The Prescription Drug Charge; or
  - (2) The pharmacy's submitted U&C Charge, if any.
- For a specific Claim for a Covered Drug dispensed by a Retail Pharmacy or Cigna Home Delivery Pharmacy, CHLIC shall charge the

Member in accordance with the terms of the Pharmacy Benefit. For example, for a Covered Drug subject to a fixed dollar copayment requirement, CHLIC shall charge the Member the lowest of the following amounts:

(1) The fixed dollar copayment for the Covered Drug, if any;

(2) The Prescription Drug Charge; and

(3) The pharmacy's submitted U&C Charge, if any.

- Home Delivery Pharmacy Dispensing Fees and Dispensing Fee Guarantees are inclusive of shipping and handling. If carrier rates (i.e., U.S. mail and/or applicable commercial courier services) increase during the term of this Agreement, the Home Delivery Pharmacy Dispensing Fee and Home Delivery Pharmacy Dispensing Fee Guarantee will be increased to reflect such increase(s).
- Unless specifically noted herein, the discounts to Employer for Covered Drugs set forth in this Agreement are not guaranteed to result in an average aggregate discount off the aggregate AWP of all such Covered Drugs.
- Any pricing guarantees, including any ingredient cost discount or Dispensing Fee guarantee, set forth in this Agreement shall be rendered null and void in the event Employer terminates CHLIC's administration of the Pharmacy Benefit prior to completion of the then-current Plan Year. CHLIC's fees, Rebates (if any), discounts or guarantees (if any) are, among other conditions communicated in this Agreement or otherwise in writing to Employer, contingent on, and assume, adoption by Employer of a specific Formulary, Retail Pharmacy network, and Plan design features (e.g. cost-share structure, utilization/cost management programs).
- Notwithstanding any other provision of this Agreement, CHLIC may, effective upon written notice to Employer, adjust any or all of the fees, Rebates (if any), discounts or guarantees (if any) in this Agreement to the extent reasonably necessary to preserve the economic value of this Agreement to CHLIC as it existed immediately prior to any of the following events or changes: (a) there are any significant changes in the composition of the CHLIC pharmacy network utilized by Employer hereunder or in such pharmacy network's contract compensation rates, or the structure of the pharmacy stores/chains/vendors that are contracted with CHLIC, including but not limited to disruption in the retail pharmacy delivery model, or bankruptcy of a chain pharmacy; or there is a change in or to the pharmacy network reflected in the pharmacy pricing summary; or (b) there is a change in government laws or regulations which has a significant impact on pharmacy claim costs; or (c) any material manufacturer-rebate contracts with, or for the benefit of, CHLIC are terminated or modified in whole or in part; or (d) there is any legal action or law that materially affects, or could materially affect the manner in which CHLIC's rebate program is administered or an existing law is interpreted so as to materially affect or potentially have a material effect, on CHLIC's administration of the Plan; (e) a major change in market conditions affecting the pharmaceutical or pharmacy benefit management market, a drug shortage in the market, an issue involving the safety of the drug supply, an unexpected introduction of a new drug (e.g. authorized generic), or similar market event occurs; (f) the Pharmacy Benefit enrollment decreases by equal to or greater than ten (10)% from the enrollment on which

CHLIC's financial offer is based; or (g) Employer fails to disclose a material feature of the Plan or the Plan's Pharmacy Benefit or there is a change to the Plan's Pharmacy Benefit including but not limited to the Formulary, benefit designs, OTC plans, clinical or trend programs or otherwise that has the effect of lowering the amount of Rebates earned hereunder or materially impacting any guarantee.

DRUG MANUFACTURER-PAYMENT SHARING

Subject to the caveats below, CHLIC will remit to Employer the following portion of Rebates that CHLIC collects with respect to utilization of Covered Drugs under the Plan's Pharmacy Benefit:

For All Products:

$175.00 per Retail Pharmacy Brand Drug Claim dispensed in a 30-day* supply, $400.00 per Retail Pharmacy Brand Drug Claim dispensed in a 90-day** supply and $700.00 per Cigna Home Delivery Pharmacy Brand Drug Claim.

Caveats:

(1) CHLIC or its agents contract with drug manufacturers on CHLIC's own behalf, and not as agent of the Employer or the Plan. Rebates are paid based on the contractual terms set forth in this Agreement.

(2) Should Employer terminate this Agreement before completion of the then-current Plan Year, no Rebates shall be due and owing with respect to that Plan Year, and any Rebate minimum or fixed dollar guarantees shall be null and void, as the payment of Rebates is conditioned on CHLIC exclusively administering the Pharmacy Benefits for the entire Plan Year.

(3) For percentage-based sharing arrangements, Rebate payout amounts may differ slightly from the stated percentage when payout occurs before manufacturers' final reconciliations and payments are made to CHLIC. For purposes of clarity, CHLIC shall reconcile its performance with respect to any Rebate payment guarantees, including, without limitation, any minimum or fixed dollar guarantees, in the aggregate. Moreover, any amount directly or indirectly provided by a manufacturer or other third party that is allocated to reduce and/or wholly or partially satisfy a Member's cost-sharing obligation for a Covered Drug shall not be considered a "Rebate" for the purposes of Rebate payments to Employer but may be included when reconciling CHLIC's performance against any Rebate minimum guarantee set forth in this Agreement.

(4) For percentage-based sharing arrangements, the percentage share payment of Rebates shall not include the payment of any Rebates received, if any, for Run-Out Claims, 340b Claims, Medical Specialty Claims, Direct Member Reimbursement Claims, Reversed Claims, and Compound Claims.

(5) CHLIC may use Rebates otherwise payable to Employer to offset payable Bank Account Payments or other payable fees or charges identified in this Agreement.

(6) The Rebate payment commitments, including any minimum or fixed dollar guarantees, if any, set forth in this Schedule of Financial Charges are, among any other conditions communicated in this Agreement or otherwise in writing to Employer, contingent on the availability of Rebates to CHLIC and Employer's Pharmacy Benefit applying a 90-day supply limit for Specialty Drugs. and standard days' supply limits. In the event that Employer has adopted, or adopts, a 30-day supply limit for Specialty Drugs, or participates in the Clinical Day Supply Program, CHLIC may revise on an equitable basis the stated Rebate minimum or fixed dollar guarantees, if any, to the extent necessary to reflect CHLIC's revised estimate of Rebates it may collect on a plan design having adopted a days' supply limit for Specialty Drug of less than 90 days or the Clinical Day Supply Program.

Timing of Rebate Pay-Out: Remittance will be provided within ninety (90) days after the close of each applicable calendar year for the portion of such calendar year that coincides with the Plan Year.

REBATE PAYMENT EXCLUSIONS

The Rebate Guarantee payment obligations set forth in this Schedule of Financial Chargess shall exclude the following types of claims and/or products:

- Claims paid pursuant to a Dispense as Written (DAW) 5 code.
- Direct Member Reimbursement Claims.
- Vaccines.
- Compound Drugs.
- Claim reversals.
- Products identified as prescriptions covered under the federal 340B drug pricing program. Employer shall be solely responsible for ensuring that any pharmacy affiliated with or operated by Employer or its affiliate, such as an in-house pharmacy, systematically identifies 340B prescriptions on Claim transactions administered by CHLIC. If such pharmacy fails to systematically identify 340B prescriptions on Claim transactions submitted to CHLIC, then CHLIC may withhold all Rebates, or modify any minimum or fixed dollar Rebate guarantee, otherwise attributable to utilization at such pharmacy.
- Run-Out Claims.

Rebate guarantee reconciliation calculations will not include member-submitted coupon copay assistance.

PHARMACY VACCINE PROGRAM

Notwithstanding anything to the contrary in this Agreement or otherwise, the following terms and conditions shall apply to the administration of vaccines by CHLIC under the Cigna Pharmacy Program.

Vaccine Claims will adjudicate at the lower of the U&C Charge or the amounts shown in the Vaccine Pricing Schedule below. For Vaccine Claims, the U&C Charge shall be the retail price charged by an in-network participating retail pharmacy for the particular vaccine, including administration and dispensing fees, in a cash transaction on the date the vaccine is dispensed as reported to CHLIC by the in-network participating pharmacy.

"Vaccine Claim" means a claim for a Covered Drug which is a vaccine.

Notwithstanding anything to the contrary in this Agreement or otherwise, all Vaccine Claims shall be excluded from the calculation, measurement, and payment of any and all financial guarantees, including but not limited to rebate guarantees, ingredient cost guarantees, and dispensing fee guarantees set forth in this Agreement.

CHLIC reserves the right to revise and modify the Vaccine Pricing Schedule below, including but not limited to revising or adding an additional Pharmacy Vaccine Administration Fee or Vaccine Program Fee, based on changing market dynamics, the entrant of new vaccines, or changes in law or interpretation of law.

Vaccine Pricing Schedule

* To the extent, if any, Employer's Schedule of Financial Charges includes a Pharmacy Administrative Fee charged on a per prescription basis, then such fee shall apply for Vaccine Claims.

	Retail Pharmacy INFLUENZA	**Retail Pharmacy ALL OTHER VACCINES**	**Member Submitted Vaccine Claims**
Pharmacy Vaccine Administration Fee	Pass-Through (Capped at $15 per in-network Vaccine Claim)	Pass-Through (capped at $20 per in-network Vaccine Claim)	Submitted amount
Ingredient Cost	Retail Pharmacy Ingredient Cost as set forth in this Agreement	Retail Pharmacy Ingredient Cost as set forth in this Agreement	Submitted amount
Dispensing Fee	Retail Pharmacy Dispensing Fee as set forth in this Agreement	Retail Pharmacy Dispensing Fee as set forth in this Agreement	Submitted amount
Vaccine Program Fee	$2.50 per vaccine claim		N/A

CIGNA HOME DELIVERY PHARMACY DISCLOSURE		
	Product	**Charge**
Cigna Home Delivery Pharmacy (a CHLIC affiliated company(ies))	Specialty drugs dispensed by Cigna Home Delivery Pharmacy and administered under the Plan's medical benefit. "Cigna Home Delivery Pharmacy" means a duly licensed pharmacy operated by CHLIC or its affiliates, where prescriptions are filled and delivered via the mail service. Cigna Home Delivery Pharmacy may maintain product purchase discount arrangements and/or fee-for-service arrangements with pharmaceutical manufacturers and wholesale distributors. Cigna Home Delivery Pharmacy contract for these arrangements on its own account in support of its pharmacy operations. These arrangements relate to services provided outside of this Agreement and other pharmacy benefit management arrangements and may be entered into without regard to whether a specific drug is on one of the formularies that CHLIC offers to entities like Employer that sponsor group health plans. Discounts and fee-for-service payments received by Cigna Home Delivery Pharmacy are not part of the administrative fees or other charges paid to CHLIC in connection with CHLIC's services hereunder. This provision shall survive termination or expiration of the Agreement.	**The drug's charge under a national specialty drug discount schedule that generates a 19.00% annual average aggregate discount off AWP across specialty drug claims dispensed at Cigna Home Delivery Pharmacy to CHLIC's self-funded and insured group-client book of business.**
FEES FOR PROCESSING RUN-OUT CLAIMS		
HRA OAP, OAP and DPPO	Run-Out Period of twelve (12) months	**No Additional Cost**
Pharmacy	Run-Out Period of three (3) months for all pharmacy claims	**No Additional Cost**

CHLIC MEDICAL COST CONTAINMENT FEES

CHLIC administers the programs listed below to contain costs with respect to charges for health care service/supplies that are covered by the Plan (the "Cost Containment Programs"). In administering these Cost Containment Programs, CHLIC may contract with vendors to perform various tasks related to the Cost Containment Programs. These Cost Containment Programs include services that are performed on claims that are subject to the federal No Surprises Act and are not otherwise subject to state law ("NSA Services").
CHLIC's charge for administering a Cost Containment Program is the applicable percentage indicated in the table below of the:

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

Program):

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

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

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

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

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

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

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

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

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

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

a. the amount of the non-Participating Provider's billed charge not exceeding the greater of a CHLIC determined percentage of the Medicare allowable amount (the 80th percentile of the reasonable and customary charge if there is no Medicare allowable charge) or the amount required by state or federal law (in some instances, the patient may be balance billed by the non-Participating Provider if the provider's charge exceeds such amount), or b. the provider's billed charge.		
Non-Participating Provider Cost Containment Programs for Services/Supplies that are not NSA Services		
1.	Network Savings Program	**29% of net savings**
2.	Supplemental Network	**29% of net savings**
3.	Medical Bill Review – (Pre-payment Cost Containment for Non-contracted claims):	
	Inpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**Lesser of 5% of hospital bill or the gross savings achieved**
	Outpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
	Physician/Professional Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
4.	For employers that are subject to state laws providing protections from surprise bills: Payment based on amounts other than Network Savings Program, Supplemental Network, and Medical Bill Review. These payments include amounts determined through negotiation or independent dispute resolution under state law. (The charges indicated in the column to the right include the fees charged by government departments or agencies for	**29% of net savings**

	administering the independent dispute resolution process and the fees charged by entities conducting independent dispute resolution.)	

B. Cost Containment for NSA Services

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

Non-Participating Provider Cost Containment Programs for NSA Services		
1.	Network Savings Program	**29% of net savings**
2.	Supplemental Network	**29% of net savings**
3.	Medical Bill Review – (Pre-payment Cost Containment for Non-contracted claims):	
	Inpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**Lesser of 5% of hospital bill or the gross savings achieved**
	Outpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
	Physician/Professional Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**

4.	Payment based on amounts other than Network Savings Program, Supplemental Network, and Medical Bill Review. These payments include amounts determined through negotiation or independent dispute resolution under the No Surprises Act. (The charges indicated in the column to the right include the fees charged by government departments or agencies for administering the independent dispute resolution process and the fees charged by entities conducting independent dispute resolution.)	**29% of net savings**
C. Other Cost Containment Programs		
1.	Clinical Complex Claim Review – (Pre- or Post-payment Cost Containment for Non-contracted and Contracted claims):	
	• Bill Audit	**29% of the gross savings/gross recovery achieved plus hospital fees or expenses passed through**
	Diagnosis Related Grouping (DRG) Validation/Audits and Recovery. An overpayment audit and recovery program in which CHLIC or its vendors review paid claim data to identify overpayments based on inaccurate DRG coding.	**29% of gross savings/gross recovery plus any fees or expenses passed through by the hospital or regulatory agency**
	• Medical Implant Device Audits	**29% of the gross savings/gross recovery**
2.	COB Vendor Recoveries [Exclusive of pharmacy programs where claims are adjudicated at time prescription is received.]	**29% of the gross recovery**
3.	Secondary Vendor Recovery Program	**29% of the gross recovery**
4.	Provider Credit Balance Recovery Program	**29% of the gross recovery**
5.	High Cost Specialty Pharmaceutical Audits (this service is only provided with respect to Medical coverage)	**29% of the gross recovery**

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

CHLIC PHARMACY COST CONTAINMENT FEES
CHLIC administers the following programs to contain costs with respect to charges for health care service/supplies that are covered by the Plan. In administering these programs, CHLIC contracts with vendors to perform program related services. CHLIC's charge for administering these programs is the percentage (indicated below) of the "recovery" (i.e. the amount recovered) as applicable.

1.	Pharmacy Vendor Recoveries. CHLIC performs periodic audits of contracted pharmacies in order to determine the accuracy of payments to the pharmacy(ies). CHLIC's recovery vendor collects and remits to CHLIC all overpayments to pharmacy(ies), and CHLIC remits to the Bank Account the balance collected from the recovery vendor, less the recovery fee set forth herein.	**30.00% of recovery**
2.	Class Action Recoveries. CHLIC identifies, monitors and may (but is not required to) participate, on behalf of Employer, in class action lawsuits or similar legal proceedings against pharmaceutical manufacturers, including, without limitation, lawsuits alleging legal or equitable claims like fraud, anti-trust violations, or unfair trade practices by a manufacturer. As part of this authority, CHLIC may participate in a settlement, exclude Employer from a settlement and/or otherwise represent Employer's interests outside the settlement. CHLIC collects and retains as a recovery fee set forth herein of any recovery (net of attorneys' fees) attributable to Employer's Plan.	**35.00% of recovery**
CHLIC DENTAL COST CONTAINMENT FEES		
Dental Cost Containment	CHLIC administers the following program to contain costs with respect to charges for dental services that are covered by the Plan. Applies to 2nd tier of participating DPPO network providers and includes: • Access to an additional network of DPPO dentists who provide care at a discounted rate. Lower out-of-pocket expenses for Members and additional claim savings for Employer when receiving covered services from these DPPO dentists. • CHLIC retains the percentage identified herein of Employer and/or Member gross savings for access and to cover the 2nd tier network administrative cost. • CHLIC calculates the percentage identified herein as fees charged on a pay-as-you save basis. If there is no savings, there is no fee charged to Employer. Gross savings are calculated by taking what the dental professional would have charged if not participating in the network minus the dentist's contracted fee. The dental cost containment fee is charged to Employer via the appropriate Electronic Funds Transfer (EFT) cycle as a percent of the savings assessed weekly against the Bank Account and would appear on Bank Account activity report(s) as Vendor Fee Reimbursement.	**25% of gross savings**

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

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

CARE MANAGEMENT/COST CONTAINMENT PROGRAM FEES		
	CHLIC arranges for third parties to provide care management services to: (i) contain the cost of specified health care services/items overall with respect to all plans insured and/or administered by CHLIC, and/or (ii) improve adherence to evidence based guidelines designed to promote patient safety and efficient patient care. Charges for these services will be processed through the Bank Account.	**Specific vendor fees and care management program services are available upon request.**
	Medical Management (inclusive of Medical Necessity Review) of Chiropractic services.	**National Average is $0.16 PMPM; rates vary by market and are available upon request.**
	Care coordination of in-home hospital level care (acute and post-acute Plan Benefits) provided by Participating Providers. The per episode charge is subject to adjustment based on vendor achieving or not achieving total cost of care savings, upon post-episode reconciliation. Vendor's fee is distinct from payment for Plan Benefits.	**Per episode charge may vary by market. Vendor, program information, and agreed upon rates available upon request.**
	In addition to such third parties, CHLIC has arranged for an affiliate, eviCore, to provide the following care management/cost-containment programs:	
	Pre-certification of coverage of radiation therapy services.	**$912.00 per episode of care (EOC)**
	Pre-certification of coverage of diagnostic cardiology services. *(If Employer has elected Basic Standard Medical Management (see Administration Charges section above) this program and charge is not applicable to that membership).*	**$0.19 PMPM**
	Pre-certification of coverage of medical oncology services.	**$1,050.00 per episode of care (EOC)**

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

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

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

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

	NOTICE REGARDING PAYMENTS FROM THIRD PARTIES	
Rebate and Other Remuneration Disclosure (Pharmacy)	CHLIC or its affiliates may contract with pharmaceutical manufacturers or other third parties for Rebates, Manufacturer Administrative Fees, and other remuneration on its or their own behalf and for its and their own benefit, and not on behalf of Employer or the Plan. Accordingly, unless otherwise specified in this Schedule of Financial Charges, CHLIC and its affiliates retain all right, title and interest to any and all actual Rebates, Manufacturer Administrative Fees, and other remuneration received from manufacturers or other third parties; neither Employer, its Members, nor Employer's Plan retains any beneficial or proprietary interest in any such remuneration, which shall be considered part of the general assets of CHLIC and its affiliates. As an example of the remuneration other than Rebates or Manufacturer Administrative Fees that CHLIC or its affiliates may earn, CHLIC or its affiliates may also directly or indirectly earn from pharmaceutical manufacturers remuneration in connection with value payments and/or services that CHLIC provides to Employer ("Value-Based Payments"). Notwithstanding anything in this Agreement to the contrary, any Value-Based Payments earned by CHLIC or its affiliates are separate and apart from any Rebates or Manufacturer Administrative Fees that CHLIC or its affiliates directly or indirectly earn from pharmaceutical manufacturers, and CHLIC and its affiliates may retain any Value-Based Payments it earns. As examples of the value payments and/or services that CHLIC may provide to Employer in connection with Value-Based Payments that CHLIC or its affiliates may earn, CHLIC may provide care management or related services to Employer and/or remit to Employer monetary credits if Members discontinue therapy on certain pharmaceutical products. Information regarding any services, and/or monetary credits or other financial value, for which Employer may be eligible with respect to specific pharmaceutical products or therapeutic classes/conditions, including the products for which monetary credits or other financial value may be available to Employer, the amount of that value, and other payment terms, is available upon request. Any value payments and/or services provided by CHLIC to Employer are subject to change or termination by CHLIC as the value program(s), if any, offered by CHLIC change(s) or terminate(s). Information on the projected aggregate amount of such Rebates with respect to the Plan Pharmacy Benefit will be provided upon request. This provision shall survive termination or expiration of the Agreement.	**All Pharmacy Products**

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

COMPLIANCE ASSISTANCE		
	CHLIC shall provide the following services to assist Employer in meeting its compliance obligations under section 2715 of the Public Health Service Act as added by the Patient Protection and Affordable Care Act and applicable regulations with respect to the provision of the Summary of Benefits and Coverage ("**SBC**"), translation notice and glossary. Applicable to all medical plans including HRA and FSA which are considered "group health plans" subject to the SBC requirements.	
1.	Preparation of SBC, translation notice. CHLIC will not be responsible for any changes that Employer makes to the SBC.	**No charge**
2.	Provide SBC, translation notices prepared by CHLIC to Employer electronically as well as any updates or material modifications.	**No charge**
3.	Include in SBC a summary of benefits administered by carve-out vendor if Employer or carve-out vendor provides CHLIC with necessary carve-out benefit information at least twelve (12) weeks prior to the date the SBCs are to be delivered to Employer.	**$500 for each benefit option under the Plan for which carve-out vendor benefits are included in SBC**
ADDITIONAL SERVICES		
Service	**Description**	**Charge**
Pharmacy Clinical Program(s)	**inMynd -** is a clinically-based Member and provider comprehensive behavioral health program that includes regular retrospective review of pharmacy and medical claim data to identify certain "at risk" (i.e., members with complex psychiatric conditions using multiple psychotropic medications) member utilization patterns to help both members and providers better recognize, treat and support mental and behavioral health conditions. **Narcotics Therapy Management -** is a clinically-based provider program that consists of a quarterly, retrospective review of pharmacy and medical claims data which helps to identify those individuals with utilization patterns that may be indicative of risk of substance abuse, overdose, or diversion.	**Included at No Additional Cost**

Pharmacy Utilization Management Program	**Essential Package** - a utilization management program under which some pharmaceutical products are subject to one or several coverage limitations, including prior authorization, step therapy and/or quantity limits. Under a prior authorization requirement, the requested drug is generally reviewed for clinical appropriateness based on the intended use in therapy. Under a step therapy requirement, the Member generally must try one or more preferred products, or demonstrate why trying the preferred product(s) would be clinically inappropriate, in order to obtain coverage for the requested drug.	**For All Products: Included in Pharmacy Administration Fee**
Clinical Program	A targeted condition medication therapy management program in which CHLIC provides support for Members using specialty medications for certain chronic conditions and that are obtained or administered at retail pharmacies or outpatient, office or home health care settings. As part of the program, Members are counseled on their condition, medication side effects, and importance of adherence. For the sake of clarity, if a specialty pharmacy affiliate of CHLIC provides therapy management for specialty medications the pharmacy dispenses to Members, then it does so in its capacity as a specialty pharmacy and not on behalf of CHLIC; CHLIC does not exert direction or control over the pharmacists at any specialty pharmacy affiliate.	**For HRA OAP** **and OAP Products: Included at No Additional Cost**
SafeGuardRx Program	A medication therapy management and cost containment program for select therapeutic conditions such as but not limited to oncology, inflammatory conditions, and multiple sclerosis and select drugs within therapeutic categories. This program seeks to help reduce drug therapy costs through its program offerings. For example, employers may qualify for the payment of discontinuation drug therapy credits and/or the reimbursement of drug therapy through drug cost caps, on select medications and therapeutic conditions. This program may also provide for Member outreach or counseling on select medications. CHLIC reserves the right to revise, modify, or terminate this program, in whole or in part, at any time. Additional and specific program information is available upon request.	**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	**For HRA OAP** **and OAP Products: Included in Medical Access Fee**

	resources is provided to those with a chronic condition, including access to online tools, personalized support, and targeted materials. The program includes the following components for those with a chronic condition: • Chronic condition-specific coaching • Pre- and post-discharge calls • Lifestyle management coaching: stress, weight management and tobacco cessation • Treatment decision support and coaching	
Alternative Litigation Management Option	Claim litigation services pursuant to the Alternative Litigation Management Option as set forth in the Agreement.	**$3,500.00 Flat Annual Amount** **Included in Medical Administration Charge**
Claim and Appeals	CHLIC will administer an optional second level of claim appeals as set forth in the Agreement.	**$0.94/Employee/Year** **Included in Medical Administration Charge**
One Guide	The One Guide advocacy solution utilizes a multimodal approach to support members and help them successfully navigate the health care system. members are serviced by personal guides that include frontline service staff, as well as clinicians and non-clinician support staff from our medical, behavioral and pharmacy programs. In addition to connecting with personal guides via telephone, members can also interact with personal guides via the click-to-chat feature on myCigna.com (web and app), enabling members to engage with CHLIC and One Guide in the way in which they prefer. One Guide helps simplify and strengthen the connection between members, their benefit plan, and their overall health and well-being. Through personalized and relevant messaging, One Guide proactively engages members with clear ways to save money, stay healthy, and improve health outcomes that lead to a healthy lifestyle. One Guide offers:	**For HRA OAP** **and OAP Products:** **$3.50/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	CHLIC will make available an internet-based self-service tool for use by Members, as well as certain data in machine-readable file format on a public website, as required under the Transparency in Coverage rule. Members can access the cost estimator tool on myCigna.com. Updated machine-readable files can be found on Cigna.com and/or CignaForEmployers.com on a monthly basis. Pursuant to Consolidated Appropriations Act (CAA), Section 106, CHLIC will submit certain air ambulance claim information to the Department of Health and Human Services (HHS) in accordance with guidance issued by HHS. Subject to change based on government guidance for CAA Section 204, CHLIC will submit certain prescription drug and health care spending information to HHS through Plan Lists Files (P1-P3) and Data Files (D1-D8) (D1-D2 for employers without integrated pharmacy product) aggregated at the Market Segment and State level, as outlined in guidance.	**Included in Medical Administration Fee**

Health Improvement Fund		
Health Improvement Fund	For clinical/wellness/behavioral programs offered by CHLIC that are purchased, CHLIC will establish a Health Improvement Fund in the amount of $100,000.00. This fund will be used to defray the cost of CHLIC designated and arranged health and wellness improvement programs (e.g. biometric screenings, flu shots) for Employees of Employer and to reward participation in these programs. The Health Improvement Fund is a one-time credit to be used from July 1, 2023-June 30, 2024. Unused funds cannot be rolled over and CHLIC must pre-approve use of the Health Improvement Fund. The Health Improvement Fund shall be extinguished upon notice of termination of the Agreement and any fund amount not used prior to the notice of termination of the Agreement shall only be available to Employer for the purpose of funding the cost of those reimbursable services provided prior to such notice of termination.	

Exhibit B – Services

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

	Perform, based on CHLIC's book of business internal audits of plan benefit payments on a random sample basis.	**All Products**
	Claim control procedures reported annually in Statement on Standards for Attestation Engagements (SSAE) No. 18 Report (or any applicable successor thereto).	**All Products**
	Respond to Insurance Department complaints.	**All Products**
	Designated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Products**
	Member Explanation of Benefit ("**EOB**") statements including, when applicable, notice of denied claims, denial reason(s) and appeal rights.	**All Products (excluding Pharmacy)**
	Verify enrollment and eligibility using Member information submitted by Employer and/or its authorized agent.	**All Products**
Medical Only		
	CHLIC's generic enrollment form is made available to Employer and eligible individuals.	**All Medical Products**
	CHLIC's standard ID card with toll-free telephone number are prepared and delivered to Members.	**All Medical Products**
	Administration of subrogation/conditional Claim Payment (terms described in Exhibit E).	**All Medical Products**
Dental Only		
	CHLIC's generic enrollment form is made available to Employer and eligible individuals.	**All Dental Products**
	CHLIC's standard ID card is a generic card, prepared and delivered to Members.	**All Dental Products**
	Standard Dental predetermination of benefits for dental procedures on a voluntary basis.	**All Dental Products**
	When elected, the Cigna Oral Health Integration Program® (OHIP) includes the provision of administrative services necessary to provide eligible Members with certain health conditions enhanced dental benefits. The program covers the following conditions: Maternity, Diabetes, Cardiovascular Programs, cerebrovascular disease (stroke), chronic kidney disease, organ transplants and head/neck cancer radiation, and is aimed at improving overall health by encouraging Members to obtain needed dental treatment by providing enhanced benefits. As appropriate, OHIP may be expanded to include new procedures, conditions and programs in the future.	**All Dental Products**

Health Care Flexible Spending Account and Dependent Care Flexible Spending Account Only		
	Providing generic enrollment forms and reimbursement request forms to Employer for use in connection with Health Care Flexible Spending Account ("**FSA**") and/or Dependent Care Flexible Spending Account ("**DFSA**") under which eligible employees (collectively "**FSA Members**") may elect to reduce their salary on a pre-tax basis up to the IRS maximum contribution allowed for deposit into a FSA and/or DFSA.	**FSA and DFSA Products**
	At the end of each reimbursement period of the Plan Year, CHLIC shall issue payments to the extent that funds remain in each FSA Member's account, for the amount that is determined by it to be proper under the Plan. At the end of the final reimbursement period of the Plan Year, CHLIC shall issue payments for any amount then due for those expenses that are determined by it to be proper under the Plan.	**FSA and DFSA Products**
	Allowable expenses for reimbursement under a DFSA include all allowable expenses incurred for the care of dependents pursuant to I.R.C. Sections 125 and 129.	**DFSA Products**
	Allowable expenses for reimbursement under a FSA include all allowable health-related expenses, pursuant to I.R.C. Sections 125 and 213 except where reimbursement under a FSA is prohibited.	**FSA Products**
	FSA Member account balances will remain open after conclusion of the Plan Year until 9/30 (the "**Run Out Period**"), so that FSA Members can submit any remaining expenses incurred during the Plan Year. For employees enrolled in the FSA on the last day of the Plan Year, claims incurred in the first 2 ½ months following the end of the Plan Year can also be submitted during the Plan run out period and applied to Plan Year unused funds. Separate account balances will be maintained as per FSA Member's election for the new Plan Year.	**FSA and DFSA Products**
	Reimbursement requests of terminating FSA Members will continue to be processed for 90 days following termination of FSA Membership for any expenses incurred prior to the FSA Membership termination date. In the case of a DFSA, reimbursement will be up to the balance in the DFSA and in the case of a FSA, reimbursement will be to the originally selected goal amount, minus prior reimbursements, regardless of whether this amount has been funded.	**FSA and DFSA Products**
	For FSA payments that are not made with a Debit Card but are a result of automatic claim forwarding ("**AutoPay**") of medical or dental claims from a medical or dental plan administered by CHLIC or Direct Submit Request For Reimbursement, an explanation of payment will be mailed to the FSA Member at their home address or, if elected, provided electronically. An explanation of payment is not issued for FSA payments that are issued to a pharmacy at the point of service as a result of automatic claim forwarding from the employee's pharmacy Plan.	**FSA Products**

	For DFSA payments made as a result of a Direct Submit Request For Reimbursement, an explanation of payment will be mailed to the DFSA Member at their home address or, if elected, provided electronically.	**DFSA Products**
	An 800 number directly linked to CHLIC's Member Services will be available for FSA Members' questions and status inquiries. This 800 number will be listed in the instructions on the reimbursement request form as well as having access to account information via Internet.	**FSA and DFSA Products**
	The Employer will identify through eligibility submission, FSA Members who elect to have medical and pharmacy claims processed but unpaid by CHLIC automatically submitted ("**rolled over**") to their FSA. Such rollover claims will be processed without additional submissions by the FSA Member and CHLIC shall be entitled to rely on the Employer's submission of the FSA Member's rollover election that the submitted expenses were properly incurred, not reimbursable from any other source and are eligible for payment under the regulations governing flexible spending accounts.	**FSA Products**
	When CHLIC takes over a FSA administration mid-Plan Year, CHLIC will provide administration services from the date CHLIC receives the FSA Plan information for claims incurred anytime during the Plan year.	**FSA and DFSA Products**
	For employees enrolled in a health care FSA plan with a debit card, a debit card will be issued to each FSA Member (employees enrolled in both a health care FSA plan with a debit card and a Health Reimbursement Account plan with a debit card will only receive one debit card covering both plans). The card is pre-loaded with the FSA Member's annual Health Care FSA goal amount for the Plan Year. Plan Year FSA funds are available using the debit card for transactions actually processed during the Plan Year period. The card does not access funds from a prior Plan period unless the Plan has the extended claim period and the Employee re-enrolls in the FSA for the subsequent period. If an Employee terminates their FSA Plan or does not re-enroll in the FSA, the debit card will be de-activated and will not be available for use after the last day of the Employee's FSA enrollment. The card is used by the FSA Member to access available FSA funds based upon the submitted goal amount less amount paid Plan Year to date from the fund. Since debits made with the card are not submitted by the card vendor to CHLIC in real-time but only on a daily basis, Employer agrees to fund all debits made by the FSA Member through the daily feed from the card vendor that indicates the FSA Member account is exhausted. The card is restricted to specific merchant types that are considered health care related. Although the card is limited to these types of merchants, the card does not limit specific items within these merchants. When the debit card is used, funds are automatically deducted from the FSA. FSA Members may be required to submit receipts to CHLIC to substantiate debit card expenditures. If appropriate substantiation is not	**FSA Products**

	received, the debit card will be suspended and no longer available for use.	
Health Reimbursement Account (HRA), Healthy Awards (HA) and Healthy Future (HF) Only		
	Providing reimbursement request forms to Employer.	**HRA Products**
	Employer will make available specific funds to eligible employees enrolled in the HRA, HA and/or HF as applicable (**"Participating Members"**). At the end of each reimbursement period of the Plan Year, CHLIC shall issue payments to Participating Members (or their medical provider, if appropriate) to the extent of the maximum amount of payment allowed by Employer reduced by prior reimbursements for the same period of coverage, for the amount that is determined by it to be proper under the Plan.	**HRA Products**
	Allowable expenses for reimbursement under a HRA, HA and/or HF, as applicable, include all allowable health-related expenses, pursuant to I.R.C. Section 213 except where payment for any such products is prohibited. The Employer can further limit the allowable expenses as agreed to by the Employer during implementation.	**HRA Products**
	Account balances for Participating Members active until the end of the Plan Year will remain open after conclusion of the Plan Year for a period of 90 days, (the **"Run Out Period"**), so that such Participating Members can submit any remaining expenses incurred during the Plan Year.	**HRA Products**
	A Participating Member's request to terminate his/her enrollment in the HRA, HA, and/or HF, as applicable, will continue to be processed for 90 days following termination for any expenses incurred prior to his/her termination date up to the originally selected goal amount, minus prior reimbursements.	**HRA Products**
	For reimbursement payments that are made as a result of automatic claim forwarding ("**AutoPay**") of medical claims from a medical plan administered by CHLIC or Direct Submit Request For Reimbursement, an explanation of payment will be made available to the Participating Member. An explanation of payment is not issued for payments that are issued to a pharmacy at the point of sale as a result of AutoPay from the employee's pharmacy Plan or for any Debit Card transactions.	**HRA Products**
	Providing information on account balances and submitted claims to Participating Members calling the number on the ID card. In addition, Participating Members will have access to account information via Internet and mobile app.	**HRA Products**
	When automatic claim forwarding ("**AutoPay**") is turned on, medical claims processed but unpaid by CHLIC will be automatically submitted for reimbursement from the HRA and/or HA Participating Member's HRA and/or HA account. Such "rollover" claims will be processed without additional submissions by the Participating Member.	**HRA Products**

	When CHLIC takes over HRA, HA and/or HF administration mid-Plan Year, CHLIC will provide administrative services from the date the Plan information is received.	**HRA Products**
	For employee enrolled in an HRA, HA and/or HF Plan with a debit card, a debit card will be issued to each HRA, HA and/or HF participating employee and spouse (if spouse is enrolled in the Plan). A debit card will also be issued upon Employee request to other eligible dependents (employee enrolled in both a health care FSA Plan with a debit card and a Health Reimbursement Account Plan with a debit card will only receive one debit card covering both Plans). The card is pre-loaded with the Participating Member's annual HRA, HA and/or HF goal amount for the Plan Year. If additional funds are added during the plan year, the card balance will automatically be adjusted. Plan Year HRA, HA and/or HF funds are available using the debit card for transactions actually processed during the Plan Year period. The card will access funds from a prior Plan period when the employee re-enrolls in the HRA, HA and/or HF for the subsequent period and has remaining HRA, HA and/or HF funds that carry over to the new period. and the debit card was active for the prior plan period. If an employee terminates their HRA, HA and/or HF Plan or does not re-enroll in the HRA, HA and/or HF the debit card will be de-activated and will not be available for use after the last day of the employee's HRA, HA and/or HF enrollment. The card is used by the HRA, HA and/or HF Participating Member to access available HRA, HA and/or HF funds based upon the submitted goal amount plus any added incentive reward dollars (if applicable) less amount paid Plan Year to date from the fund. Since debits made with the card are not submitted by the card vendor to CHLIC in real-time but only on a daily basis, Employer agrees to fund all debits made by the Participating Member indicated through the daily feed from the card vendor, until the Participating Member's account is exhausted. The card is restricted to specific merchant types that are considered health care related based on service category elections. Although the card is limited to these types of merchants, the card does not limit specific items within these merchants, unless they are an inventory information approval system ("IIAS") merchant with The Special Interest Group for IIAS Standards ("SIGIS"). When the debit card is used, funds are automatically deducted from the HRA, HA and/or HF. HRA, HA and/or HF Participating Members may be required to submit receipts to CHLIC to substantiate debit card expenditures. CHLIC will attempt to obtain the appropriate documentation from the participant via mail or email. If appropriate documentation to substantiate the transaction is not received, the debit card will be suspended and no longer available for use.	**HRA Products**

	Pharmacy claims: Eligible pharmacy expenses, under the HRA, HA and/or HF that are processed but unpaid by CHLIC may be automatically submitted ("rolled over") to the Reimbursement Accounts Claim Office for reimbursement from the Participating Member's HRA, HA and/or HF account if the AutoPay option is enabled. Such rollover claims will be processed without additional submissions by the Participating Member. When pharmacy is covered and Cigna Pharmacy is the pharmacy vendor, the HRA, HA and/or HF will automatically pay the pharmacy through the HRA, HA and/or HF at the point of sale for all Participating Member obligations under the pharmacy Plan including deductibles, copays, and/or coinsurance obligations. A Participating Member will not receive an Explanation of Benefits for these payments.	**HRA Products**
PLAN BOOKLET		
	Prepare and make accessible Member benefit booklet drafts to Employer.	**All Products**
UNDERWRITING SERVICES		
	5500 Schedule C reporting.	**All Products**
	5500 Schedule A or Annual Reconciliation Disclosure reporting (when applicable)	**All Products**
	CHLIC's standard Underwriting services: a) benefit design analysis b) projected cost analysis.	**All Products**
HIPAA INDIVIDUAL RIGHTS		
	Handling of requests from Members for access to, amendment and accounting of protected health information, and requests for restrictions and alternative communications as required under federal HIPAA law and regulations, as set out in this Agreement and its Exhibits.	**All Products**
COST CONTAINMENT		
	Maximum reimbursable charge determinations of non-Participating Provider charges for covered services.	**All Medical Products (with out-of-network benefits)**
	CHLIC's standard cost containment controls: Application of non-duplication and coordination of benefits rules and coordination with Medicare.	**All Medical Products**
	Delivery of information, as necessary, regarding standard application of non-duplication or coordination of benefits.	**All Medical and Dental Products**
	Review of medical bills in accordance with CHLIC's then current Medical Bill Review program.	**All Medical Products**
	Dental Cost Containment, as reflected in the Schedule of Financial Charges.	**All Dental Products**

	Pharmacy Cost Containment, as described in the Schedule of Financial Charges.	**All Pharmacy Products**
	Medical Cost Containment, as reflected in the Schedule of Financial Charges.	**All Medical Products**
	Annual reporting of CHLIC's standard cost containment results upon Employer's request.	**All Medical and Dental Products**
	REPORTING	
	Summary reports of medical, dental and pharmacy cost and utilization experience (where applicable), upon completion of internal report generation, are available through Cigna's web site, CignaforEmployers.com.	**All Medical, Dental and Pharmacy Products**
	CHLIC's standard pharmacy utilization reports.	**Pharmacy Product Only**
	Claim Reporting: CHLIC will provide standard banking and financial report information based upon paid claim data. CHLIC will not provide information on incurred-but-not reported claims, projected claims, pre-certifications of coverage, case management information or information on a Member's prognosis or course of treatment.	**All Medical and Pharmacy Products**
	Individual Stop Loss Reporting is an optional service provided at an additional fee to employers who have individual stop loss through another entity other than CHLIC. CHLIC will provide its standard Individual stop loss reporting package, which includes banking and financial information based upon paid claims data, only after the stop loss carrier and Employer have executed CHLIC's standard Hold Harmless/Confidentiality Agreement. Aggregate Stop Loss Reporting is not included as part of the standard reporting package and is not provided. CHLIC will not provide documentation and information, including but not limited to, incurred-but-not-paid claims, projected claims, pre-certifications of coverage, case management records and notes, course of treatment or prognosis, and internal audits. CHLIC does not allow stop loss carriers to audit CHLIC's claims administration under the medical benefit plan, however, the Employer's audit rights are set forth in the Agreement. For the sake of clarity, as it is possible that certain information, documentation, data and/or reports that are required by the stop loss carrier prior to reimbursement under Employer's stop loss policy will not be available for stop loss policy administration, Employer is responsible for verifying any such required information with its stop loss carrier.	**All Medical Products**
	CHLIC's standard management and statistical reports for Employer.	**FSA and DFSA Products**
	CHLIC's standard Individual Summary Statements for applicable participating Members.	**FSA, DFSA and HRA Products**

	CHLIC's standard Health Reimbursement Account, Healthy Awards and/or Healthy Future activity report for Employer.	**HRA Products**
	COMPLIANCE	
	Employer directs CHLIC in administering the Health Care Flexible Spending Account, Healthy Awards, Healthy Futures and/or Health Reimbursement Account benefit to comply with COBRA as follows:	
	Each FSA Member who experiences a qualifying event and elects continuation of account coverage in accordance with COBRA will be maintained until the earlier of the end of the Plan Year, the exhaustion of the FSA balance or other termination of the FSA.	**FSA Products**
	FSA Members electing continuation of FSA coverage under COBRA will continue contributions at a rate not to exceed 102% of the applicable premium. The Employer may require after-tax contributions, or may allow the continuant to elect a lump-sum salary reduction in the amount required in contributions for the remainder of the coverage period.	**FSA Products**
	FSA Members who continue under COBRA and whose contributions have been made as required may submit Reimbursement Requests for themselves and any eligible dependents, for expenses incurred before or after the date of the qualifying event but prior to the end of the coverage period. Requests may be submitted until the earlier of the end of the Plan Year or the termination of the FSA, including any applicable Run-Out Period.	**FSA Products**
	The HRA, HA and/or HF of each HRA, HA and/or HF Participating Member who experiences a qualifying event and elects continuation of account coverage in accordance with COBRA will be maintained similar to the maintenance of an active Employee. HF Participating Members that have not met their vesting requirements determined by the plan are not required to be offered COBRA for the HF.	**HRA Products**
	MEMBER EXTERNAL REVIEW PROGRAM	
	CHLIC contracts with a minimum of three (3) independent review organizations that meet the Patient Protection and Affordable Care Act (PPACA) external review requirements. Members may appeal eligible claims requiring medical judgment to an external independent review organization which is selected by CHLIC on a random basis. If Employer has chosen not to participate in this program, the Employer may be responsible for making other arrangements to meet the Patient Protection and Affordable Care Act (PPACA) external review requirements.	**All Medical Products**

MEDICAL MANAGEMENT SERVICES		
	CHLIC provides integrated medical management that includes (depending upon the terms of the Plan) the following core services.	
	Pre-Admission Certification and Continued Stay Review (PAC/CSR) services to certify coverage of acute and sub-acute inpatient admissions/stays or provides guidance to appropriate alternative settings. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products**
	Case Management, a service designed to provide assistance to a Member who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support.	**All Medical Products**
	Assist providers with resources and tools to enable them to develop long term treatment plans in the management of chronic or catastrophic cases.	**All Medical Products**
	The Cigna HealthCare Healthy Babies Program is an educational program which provides Member with prenatal care education and resources to help them better manage their pregnancy. Other benefits of this program include the Health Information Line, high risk maternity and pregnancy information on myCigna.com.	**All Medical Products**
	HealthCare Cost and Quality tools available on myCigna.com and myCigna mobile app.	**All Medical Products**
	A panel of physicians and other clinicians to assess the safety and effectiveness of new and emerging medical technologies. The panel meets monthly to review and update coverage policies.	**All Medical Products**
	Health Information Line is a service that provides twenty-four (24) hour toll free access to nurses who provide convenient and confidential services. Health Information Line nurses can help guide Members in finding the right care, make informed decisions about symptom-based health issues the Member is experiencing when they call the Health Information Line and recommend appropriate 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.	**All Medical Products**
	Cigna LifeSOURCE Transplant Network® contracts with more than one hundred seventy (170) independent transplant facilities which includes over eight hundred (800) transplant programs and provides access to solid organ and bone marrow/stem cell transplantation while improving cost containment and reducing financial risk.	**All Medical Products**
	A health education program that delivers mailings to Members with certain conditions.	**All Medical Products**

	Behavioral health services are provided/arranged by a CHLIC affiliate (details available upon request), including utilization review and case management for both inpatient and outpatient, in-network behavioral health services.	**HRA OAP and OAP Products: (All Members)**
	Implement a quality oversight process that includes monitoring of utilization management performance measurements and a continuous quality improvement process when warranted.	**All Medical Products**
	Transition of care services to allow Members with defined conditions to continue treatment with non-Participating Providers after enrollment for continued uninterrupted care for a limited time.	**All Medical Products Except Comprehensive and Indemnity**
	Focused utilization management of outpatient procedures and identification of appropriate alternatives. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products with Care Management Preferred**
NETWORK MANAGEMENT SERVICES		
	CHLIC, and/or its affiliates or contracted vendors shall:	
	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, fixed per person per period, per diem charges, incentive bonuses, case rates, withholds etc.). The amount and type of negotiated reimbursement may vary depending upon the type of plan. For example, a hospital may accept less for patients enrolled in certain types of plans than others. In addition, CHLIC may contract with Participating Providers and other parties (for example Independent Practice Associations) for performance-based incentive payments to promote quality of care, patient safety and cost efficiency.	**All Medical and Pharmacy Products**
	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, fixed per person per period, per diem charges, incentive bonuses, case rates, withholds etc.). In addition, CHLIC may contract with Participating Providers and other parties for performance-based incentive payments to promote quality of care, patient safety and cost efficiency;	**All Dental Products**

	Credential and re-credential Participating Providers in accordance with CHLIC's credentialing requirements and ensure that third-party network vendors credential/re-credential Participating Providers in accordance with CHLIC's requirements;	**All Medical, Dental and Pharmacy Products**
	Monitor Participating Provider compliance with protocols and procedures for quality, Member satisfaction, and grievance resolution;	**All Medical, Dental and Pharmacy Products**
	Facilitate the identification of Participating Providers by Members; and	**All Medical, Dental and Pharmacy Products**
	Designated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Medical, Dental and Pharmacy Products**
	Access to online and/or on demand medical and health-related consultations via secure telecommunications technologies, telephones and internet are permitted and may include MDLIVE, a CHLIC affiliate (see details on myCigna.com).	**All Medical Products**
	BEHAVIORAL HEALTH	
	CHLIC has contracted with an affiliate (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 Employer's monthly reporting and on financial documents. Such payments will be at the relevant monthly rates then in effect. The monthly rates paid to 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 . 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) will be paid from the Bank Account as claims and will appear in Employer's monthly reporting.	**These services are included in the following products:** **HRA OAP** **and OAP Products**

CIGNA STAFF MODEL HEALTHPLAN SERVICES		
	The Cigna HealthCare of Arizona, Inc. staff model ("**Cigna Medical Group**" or "**CMG**") is a multispecialty participating provider group located in metropolitan Phoenix, Arizona. CMG's integrated care delivery model and population health management team work together to facilitate the way in which patients and doctors communicate and interact in order to increase patient satisfaction and improve health outcomes. Plan Participants may at some time receive treatment from a CMG facility or provider even if they do not reside in Arizona (as when traveling). Plan Participants utilizing Cigna participating provider networks in Arizona may access certain specialty and/or ancillary services (such as imaging and urgent care services) through the CMG system. For covered services provided to Participants, CMG is paid at the rates in effect at the time of service (as may be revised from time to time). Representative rates for routinely performed services are attached to the Schedule of Financial Charges herein. A complete copy of the rates is available on request under a mutually agreed nondisclosure agreement ("**NDA**"). If the Plan requires or allows Participants to select a primary care provider ("**PCP**"), Phoenix area Participants who do not select a PCP during open enrollment may be assigned to or otherwise encouraged to consider a CMG PCP. CMG has established collaborative referral relationships with specialty and ancillary providers in Cigna's participating provider networks, which includes affiliated entities. CMG may also receive applicable performance-based incentive payments for its participation in programs designed to improve quality, patient safety and affordability. The incentive payments that CMG may receive will be determined using the same performance measures and reward formula as used in determining the incentive payments made to similarly situated non-Cigna affiliated provider entities. The amount of the incentive payments made to CMG and attributable to the plan will be provided upon request.	**All Medical Products**

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

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

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

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

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

Exhibit E – Conditional Claim/Subrogation Recovery Services

I. Plans Without CHLIC Stop Loss Coverage

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

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

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

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

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

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

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

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

II. Plans with CHLIC Stop Loss Coverage

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

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

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

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

Appendix A – Pharmacy Benefit Management Services

PHARMACY BENEFIT MANAGEMENT - DEFINITIONS

Definitions

Any capitalized term not defined below shall have the meaning given to such term in the Agreement. Any capitalized term utilized in the Schedule of Financial Charges or Exhibit B shall have the meaning given to such term in the Agreement, including the meanings set forth below.

- "Actuarially Estimated" shall mean that the discount(s) listed in the Schedule of Financial Charges are estimated, but not guaranteed, to result in a particular average discount for Covered Drugs administered by CHLIC under this Agreement. Actuarially estimated discounts are calculated based on evaluation of an expected distribution of drug utilization across CHLIC's aggregate group client book of business. As measured in the aggregate for Employer's Pharmacy Benefit, Employer's average discount results may vary based on the Plan-specific factors such as drug mix utilization.

- "Authorized Generic" shall mean a pharmaceutical product sold, licensed, or marketed under a new drug application (NDA) approved by the Food and Drug Administration (FDA) under section 505(c) of the Federal Food, Drug and Cosmetic Act (FFDCA) that is marketed, sold or distributed under a different labeler code, product code, trade name, trademark, or packaging (other than repackaging the listed drug for use in institutions) than the innovator brand name drug.

- "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"), Covered Drug specific, quantity appropriate actual package size (or the manufacturer-packaged quantity closest to the dispensed size), submitted by a Retail Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy 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, including, for example, any change in the markup, methodologies, processes or algorithms underlying the published AWP(s), CHLIC may adjust any or all of the Rebates, charges, rates, discounts, guarantees and/or fees in connection with CHLIC's administration of the Pharmacy Benefit hereunder, including any that are based on AWP, as it reasonably deems necessary to preserve the economic value or benefit of this Agreement to CHLIC as it existed immediately prior to such change. Additionally, and notwithstanding any other provision in this Agreement, CHLIC may replace AWP as its pharmaceutical pricing benchmark with an alternative benchmark and/or may replace Medi-Span, or other such publication, as its source for the AWP or alternative benchmark with a different pricing source, provided that CHLIC adjusts any or all such AWP-based charges or such alternative benchmark-based charges as it reasonably deems necessary to preserve the economic value or benefit of this Agreement to CHLIC as it existed immediately prior to such replacement or immediately prior to the event(s) giving rise to such replacement, as the

case may be.

- "Biosimilar" shall mean a biological product that is licensed by the FDA as a biosimilar pursuant to Section 351(k) of the Public Health Service Act, 42 U.S.C. 262(k), based upon a showing that it is highly similar to a single FDA-licensed biological product, known as a reference product, and has no clinically meaningful differences compared to the reference product in terms of safety, purity, and potency. A biosimilar biological product may be licensed by the FDA as biosimilar or interchangeable, and in either case such biological product is a Biosimilar for the purposes of this Agreement.
- "Brand Drug" shall mean a pharmaceutical product, including a Covered Drug that is a prescription drug, including over-the-counter drugs dispensed pursuant to a prescription, medicine, agent, substance, device, supply or other therapeutic product that is not a Generic Drug. Except if and where the language expressly states otherwise, a Brand Drug does not include a Specialty Brand Drug for ingredient cost discount purposes.
- "Cigna Home Delivery Pharmacy" shall mean a duly licensed pharmacy operated by CHLIC or its affiliates, where prescriptions are filled and delivered via the mail service, which may include, for example, Accredo Health Group, Inc., ESI Mail Pharmacy Service, Inc., Express Scripts Pharmacy Inc., Express Scripts Specialty Distribution Services, Inc. and Lynnfield Drug, Inc. (dba Freedom Fertility Pharmacy).
- "Claim," for purposes of this Appendix A, is a claim or request for coverage under the Pharmacy Benefit.
- "Compound Drug" shall mean a medication that (a) is comprised of two or more gaseous, solid, semi-solid, or liquid ingredients (other than water or flavoring added to any preparation) that are weighed or measured at a pharmacy and then prepared according to the prescriber's order and the pharmacist's art; (b) contains at least one FDA-approved federal legend drug as an active ingredient; (c) is not otherwise generally available in its compound form; and (d) is not a compound preparation administered by infusion or injection.
- "Covered Drugs" shall mean prescription drugs, including over-the-counter drugs dispensed pursuant to a prescription, biologics, medicines, agents, substances, devices, supplies, and other therapeutic products that are prescribed for Members and are covered under the Pharmacy Benefit and shall include all associated standard services usually and customarily rendered by a pharmacy or provider in the normal course of business, including dispensing, administration, counseling and product consultation.
- "Dispensing Fee" means an amount paid to a pharmacy for providing professional services necessary to dispense a Covered Drug to a Member.
- "FDA" shall mean the U.S. Food and Drug Administration.

- "Formulary" shall mean the list of FDA-approved prescription drugs and supplies developed and managed by CHLIC across its self-funded and insured group book of business and that is selected and adopted by Employer. The drugs and supplies included on the Formulary will be modified by CHLIC from time to time as a result of factors including, but not limited to, economic and clinical factors like clinical appropriateness, manufacturer Rebate arrangements and patent expirations. Any changes CHLIC makes to the Formulary are hereby adopted by Employer, subject to Employer's discretion to elect not to implement any such addition or deletion through the set-up process, any such election shall be considered an Employer change to the Formulary.

- "Generic Drug" means a pharmaceutical product, including a Covered Drug, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the FDA as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient(s), and which is identified as such in CHLIC's master drug file using indicators from First Databank, Medi-Span, or other nationally recognized source as used by CHLIC across its book of business on the basis of a proprietary algorithm, a summary of which may be made available for review by Employer or, subject to CHLIC's consent, its auditor upon request in accordance with the terms set forth in this Appendix A. Employer and, as applicable, its auditor shall sign a confidentiality agreement acceptable to CHLIC relating specifically to such summary. The reference to a drug by its chemical name does not necessarily mean that the product is recognized as a generic for adjudication, pricing or copay purposes. Except if and where the language expressly states otherwise, a Generic Drug does not include a Specialty Generic Drug for ingredient cost discount purposes. For pricing purposes, a Generic Drug excludes a Covered Drug that is either marketed under three (3) or fewer Abbreviated New Drug Application pursuant to 21 U.S.C. §355, and its implementing regulations, or cannot be purchased by the pharmaceutical industry at large from more than one (1) pharmaceutical wholesaler. For pricing purposes, a Generic Drug also excludes a Biosimilar.

- "Limited Distribution Drug" or "Exclusive Distribution Drug" shall mean a Specialty Drug that is not generally available from most or all pharmacies but is restricted to select pharmacies as determined by a pharmaceutical manufacturer. The list of Limited Distribution Drugs and Exclusive Distribution Drugs will be maintained by CHLIC.

- "Maximum Allowable Charge" shall mean the maximum unit price for a Covered Drug included on the applicable MAC List as set forth on such MAC List.

- "MAC List" shall mean a then-current list maintained by CHLIC of prescription drugs, devices, supplies and over-the-counter drugs identified as readily available as a Generic Drug or generally equivalent to a Brand Drug (in which case it may also be on a MAC List) and that, in each case, are deemed to require or are otherwise capable of pricing management due to the number of manufacturers, utilization and/or pricing volatility.

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

- "Pharmacy Benefits" shall mean amounts payable for covered pharmacy benefit services and products under the terms of the Plan; Pharmacy Benefits shall be considered Plan Benefits for purposes of this Agreement.

- "P&T Committee" shall mean a committee comprised of clinicians that represent a range of clinical specialties. The committee regularly reviews pharmaceutical products, new pharmaceutical products, for safety and efficacy, the findings of which clinical reviews inform coverage status decisions made by CHLIC. The P&T Committee's review may be based on consideration of, without limitation, FDA-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

- "PBM Proprietary Information" shall mean information relating to CHLIC's pharmacy benefit management products and services, including, without limitation, CHLIC's reporting and web-based applications, eligibility and adjudication systems and coding methodologies, system formats and databanks, clinical or formulary management operations or programs, information and agreements relating to Rebates and other financial information, prescription drug evaluation criteria and coverage policies, drug pricing information, including MAC List and Specialty Drug pricing, paid Claims information integrated into CHLIC's adjudication systems, and pharmaceutical manufacturer, vendor or pharmacy network agreements.

- "Prescription Drug Charge" shall mean the amount that, prior to application of the Plan's cost-share requirement(s), Employer is obligated to pay for a Covered Drug dispensed at a Retail Pharmacy or Cigna Home Delivery Pharmacy, including any ingredient cost, applicable Dispensing Fee, service fee, and tax. The ingredient cost charged to Employer may be expressed as, for example, a discount off of AWP or other benchmark price, or a MAC.

- "Rebate" shall mean retrospective formulary rebates received by CHLIC pursuant to the terms of a formulary rebate contract negotiated independently and directly attributable to or arising from the utilization by Members of certain Covered Drugs manufactured, sold, marketed, or distributed by a manufacturer.

  However, "Rebates" shall exclude: (i) pricing adjustments, payments and credits made in the ordinary course by any manufacturer on account of product returns, delivery errors or shipping damage or losses arising from drugs and other products purchased from such manufacturer by or on behalf of CHLIC (ii) pricing discounts paid or credited by a manufacturer to pharmacies affiliated with CHLIC for prescription drugs and other products purchased from such manufacturer; (iii) any fees or other compensation paid by any manufacturer in consideration of any services, products, activities or programs performed, provided or implemented by CHLIC or any of its affiliates for such manufacturer; (iv) Manufacturer Administrative Fees; (v) Value-Based Payments; (vi) any rebates or other amounts that are allocated to reduce and/or partially or wholly satisfy a Member's cost-sharing obligation for a Covered Drug; and (vii) rebates or other amounts paid to CHLIC for prescription drugs that are administered or otherwise provided to Members in providers' offices, home health care settings, or outpatient clinics.

- "Retail Pharmacy" shall mean any licensed retail pharmacy with which CHLIC has contracted directly or indirectly with a third party, to provide Covered Drugs to Members, and is not a mail order pharmacy. A mail order pharmacy is a pharmacy that primarily fills and delivers pharmaceutical products via the mail service. The term "Retail", when immediately preceding the term "Brand Drug Claim", "Generic Drug Claim", "Specialty Drug Claim", "Specialty Brand Drug Claim", or "Specialty Generic Drug Claim" means that the resulting term (e.g., "Retail Brand Drug Claim") refers to such claim as dispensed by a Retail Pharmacy.

- "Specialty Drug" shall mean a pharmaceutical product, including a Covered Drug, considered by CHLIC to be a Specialty Drug based on consideration of the following factors: (i) whether the pharmaceutical product is prescribed and used for the treatment of a complex, chronic or rare condition; (ii) whether the pharmaceutical product has a high acquisition cost; and, (iii) whether the pharmaceutical product is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Drug may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a pharmaceutical product will be considered a Specialty Drug. The term "Specialty," when immediately preceding the terms "Generic Drug" or "Brand Drug", means that the resulting term (e.g. "Specialty Generic Drug") refers to a Generic Drug or Brand Drug that is considered a Specialty Drug, respectively.

- "Specialty Pharmacy" shall mean a duly licensed pharmacy designated by or operated by CHLIC or its affiliates that primarily dispenses Specialty Drugs or provides services related thereto; provided, however, that when the Cigna Home Delivery Pharmacy dispenses a Specialty Drug, it shall be considered a Specialty Pharmacy hereunder.

- "U&C Charge" shall mean the price the applicable Retail Pharmacy would charge a regular cash-paying customer for a Covered Drug (and any services related to the dispensing thereof) on the day on which the Covered Drug is dispensed.

PHARMACY BENEFIT MANAGEMENT - SERVICES TO BE PROVIDED

1. **Retail Pharmacy Network**.

   (a) General. CHLIC shall maintain a Retail Pharmacy network. Retail Pharmacies included in the network shall provide Covered Drugs to which the Retail Pharmacies have access to Members during their normal business hours. A list of the Retail Pharmacies included in the network, as updated from time to time, shall be made available to Members online. CHLIC maintains multiple networks and/or sub-networks and may periodically consolidate networks and/or migrate clients, including Employer, between networks and sub-networks. CHLIC shall require each Retail Pharmacy included in the network to meet its requirements for participation in the Retail Pharmacy network, which include, but are not limited to, satisfaction of licensing and insurance requirements.

   (b) Retail Pharmacy Audits and Overpayments. CHLIC shall review 100% of all claims, with each claim to be reviewed by either desk audit or field audit as determined through the use of random risk based predictive model to ensure that each Retail Pharmacy

is complying with the terms of its contract with CHLIC. In the event that CHLIC discovers that an overpayment has been made to a Retail Pharmacy, CHLIC shall take reasonable steps to recover the overpayment pursuant to the terms of this Agreement.

(c) Independent Contractors. The Retail Pharmacies are independent contractors, and as such CHLIC does not direct or exercise any control over the pharmacists at Retail Pharmacies or the professional judgement exercised by any pharmacies in the dispensing or filling of prescriptions or performing other pharmaceutical services. Neither CHLIC nor any CHLIC affiliate shall have any liability to Employer, any Member or any other person or entity for any act or omission of any Retail Pharmacy or it agents or employees.

(d) Collection of Cost Sharing. CHLIC shall require Retail Pharmacies to collect all applicable Plan cost-shares from Members.

2. Cigna Home Delivery Pharmacy.

(a) General. Members may submit new or refill prescription orders for fulfillment through Cigna Home Delivery Pharmacy or such other mail service pharmacy that CHLIC in its sole discretion may select from time to time. Such orders may be placed via mail, telephone, or electronic means. Subject to Applicable Law, Employer shall permit communication with Members regarding the availability and use of the Cigna Home Delivery Pharmacy, and potential cost savings associated therewith, and the provision of supporting services (e.g. pharmacist consultation) in connection with any prescription dispensed by the Cigna Home Delivery Pharmacy. Cigna Home Delivery Pharmacy shall deliver all drugs to Members in accordance with its standard procedures. For the purposes of clarity, CHLIC does not exert direction or control over the pharmacists at Cigna Home Delivery Pharmacy in filling prescriptions or performing other pharmaceutical services.

(b) Cost Sharing. Members are responsible for the payment of the applicable cost sharing to Cigna Home Delivery Pharmacy for each prescription or prescription refill. Employer acknowledges that Cigna Home Delivery Pharmacy may suspend services to a Member who is in default of any cost-sharing obligations, in accordance with Cigna Home Delivery Pharmacy's standard credit policy. If payment of such cost-sharing has not been received from the Member within one hundred twenty (120) days of dispensing of the product, the Plan will be billed for the outstanding amount following the one hundred twenty (120) day collection period.

(b) Affiliation with CHLIC. Accredo Health Group, Inc., ESI Mail Pharmacy Service, Inc., Express Scripts Pharmacy Inc., Express Scripts Specialty Distribution Services, Inc. and Lynnfield Drug, Inc. (dba Freedom Fertility Pharmacy) are licensed pharmacy affiliates of CHLIC that fill and deliver Covered Drugs via the mail service.

3. Claims Processing.

(a) General. CHLIC, in accordance with Section 2 of the Agreement, shall perform claims processing services for Covered Drugs dispensed by Retail Pharmacies or Cigna Home Delivery Pharmacy. In-network Claims shall be submitted via paper or electronically. Members using out-of-network covered services are required to submit a paper claim form. A separate charge may apply for the submission of any paper claim form, whether in-network or out-of-network. CHLIC is not required to provide coordination of benefits (COB) services for Claims for drugs dispensed, and electronically processed, at a pharmacy; Claims may be processed without consideration of a Member's coverage under another plan.

(b) Drug Utilization Review. CHLIC shall perform a concurrent Drug Utilization Review ("DUR") analysis of each prescription submitted for processing. Such DUR Analysis may include, for example: (1) prescribed dosage within a safe range; (2) drug-to-drug interaction; (3) drug-to-allergy interaction; (4) age-to-drug interaction; (5) duplicate therapy; (6) quantity limitations; and (7) days' supply. DUR processes shall not override the prescriber's, the pharmacist's or other health care provider's professional judgment.

4. **Utilization Management Program**. CHLIC shall, in accordance with Section 2 of the Agreement administer the Pharmacy Benefit utilization management program(s) identified in this Agreement. Employer acknowledges that CHLIC's coverage policies and claims administration procedures, which are utilized across CHLIC's self-funded and insured book-of-business to adjudicate claims and administer appeals, may change periodically. As an example of the coverage criteria that may apply to a pharmaceutical product, a Member may have to try one or more preferred pharmaceutical products, or demonstrate why trying the preferred pharmaceutical product(s) would be clinically inappropriate, in order to obtain coverage under the Plan for a given pharmaceutical product Employer further authorizes CHLIC to allow coverage for a use that would otherwise be excluded in the event of co-morbidities, complications and other factors not expressly addressed by the coverage policies utilized by CHLIC in reviewing Claims for coverage. CHLIC may rely wholly upon information about the Member and the prescriber's diagnosis of the Member's condition. CHLIC shall not substitute its judgment for the judgment of the prescribing physician, nor shall it determine medical necessity or make other medical determinations other than for coverage purposes.

5. **Rebate Management**. CHLIC shall pay Employer amounts equal to the Rebate amounts specified in the Schedule of Financial Charges.

6. **Drug-Related Services**.

(a) Specialty Drugs. CHLIC shall process Claims regarding Specialty Drugs subject to the following provisions:

(1) The Specialty Pharmacy shall fill prescriptions for Specialty Drugs based on the professional judgment of the dispensing pharmacist, accepted pharmacy practices and product guidelines.

(2) A list of Specialty Drugs available via the Specialty Pharmacy and the pricing for those Specialty Drugs shall be made available as in effect on the Effective Date, as set forth in Appendix B. After the Effective Date, Employer may request that CHLIC provide it with an updated list of Specialty Drugs available via the Specialty Pharmacy and the pricing with respect thereto.

(3) To the extent acting in the capacity as a mail order pharmacy, the Specialty Pharmacy shall ship Specialty Drugs to Members in accordance with its standard procedures.

(4) Members are responsible for the payment of the applicable cost sharing to the Specialty Pharmacy for each prescription or prescription refill. Employer acknowledges that the Specialty Pharmacy may suspend services to a Member who is in default of any cost-sharing obligations, in accordance with the Specialty Pharmacy's standard credit policy. If payment has not been received from the Member within one hundred twenty (120) days of dispensing, the Plan will be billed following the one hundred twenty (120) day collection period.

(5) For the purposes of clarity, CHLIC does not exert direction or control over the pharmacists at the Specialty Pharmacy in filling prescriptions or performing other pharmaceutical services.

(b) Compound Drugs. CHLIC shall process prescribed Compound Drugs to the extent covered under the Plan. CHLIC shall treat as Covered Drugs only those components of a Compound Drug that would otherwise be treated as Covered Drugs were they not part of a Compound Drug.

7. **Member Communications and Services**.

(a) Member Communication. CHLIC shall provide to Members an ID card and instructions to access Member materials online, including the Formulary, the Retail Pharmacy directory, Cigna Home Delivery Pharmacy information, and an out-of-network Claim reimbursement form.

(b) Rx Savings Messenger. CHLIC may send personalized mailings to Members regarding the Generic Drugs and preferred Brand Drugs and savings available from Cigna Home Delivery Pharmacy.

(c) Call Center. CHLIC shall maintain toll-free customer service lines twenty-four (24) hours per day, seven (7) days per week for the purpose of responding to inquiries from Members regarding Retail Pharmacy, Cigna Home Delivery Pharmacy or Claims issues.

8. **Formulary Management; Clinical Programs; Other Services**.

CHLIC shall provide Formulary management services, which shall include implementing Formulary placement decisions and determinations to apply utilization management requirements made by CHLIC. CHLIC makes Formulary determinations based on consideration of clinical and economic factors. Clinical factors may include, but are not limited to, the CHLIC P&T Committee's evaluation of the place in therapy, relative safety or relative efficacy of the drug, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the drug's acquisition cost including, but not limited to, assessments on the cost effectiveness of the drug and available Rebates. Employer acknowledges that the Formulary, utilization management requirements, and coverage policies used by CHLIC to perform coverage reviews, including any changes made thereto, are adopted by Employer. When considering a drug for Formulary placement or other coverage conditions, CHLIC reviews clinical and economic factors regarding enrollees as a general population across its relevant book-of-business. CHLIC may also provide the clinical, safety and/or trend programs, or other programs and services to Employer, some of which may require payment of additional fees by Employer. If additional fees are required for such a program or service, CHLIC shall include the fee in the Schedule of Financial Charges or otherwise communicate the same in writing to by Employer.

PHARMACY BENEFIT MANAGEMENT - PROGRAM OPERATIONS

1. **Implementation of Agreement**.

   (a) Project Plan. Employer and CHLIC shall develop an agreed upon implementation project plan with respect to the Agreement prior to the Effective Date or prior to the implementation with respect to any new Pharmacy Benefit under this Agreement following the Effective Date.

   (b) Initial Data and Commencement of Pharmacy Benefit Management Services. Prior to the Effective Date, Employer shall provide CHLIC with all data and/or documentation necessary for CHLIC to provide the services specified in this Agreement. Such data and/or documentation shall include, but is not necessarily limited to, claims history and Member prior authorization history. Assuming all data specified in the preceding sentence is received sufficiently in advance of the Effective Date, CHLIC shall commence providing services under this Agreement as of the Effective Date.

2. **Timely Provision of Data by Employer**. Employer acknowledges that CHLIC shall not be held responsible for, and shall be released from, fulfilling any obligation or performing any service under this Agreement if Employer or its designee does not provide accurate information in a timely manner.

3. **Reporting**. CHLIC shall make available to Employer CHLIC's standard reporting applications, subject to Applicable Law and Exhibit D, including, without limitation, HIPAA and state privacy laws.

4. **Claims Data**.

(a) Retention. CHLIC shall retain data with respect to Claims for at least ten (10) years from the date the prescription is filled. Following the close of such retention period, CHLIC shall retain and dispose of such Claims data pursuant to its then-current standard policies and procedures, Applicable Law and the Business Associate Agreement described in the Agreement.

(b) Disclosure to Vendor. Upon Employer's written request and subject to execution of a non-disclosure agreement acceptable to CHLIC, CHLIC shall provide prescription Claims data in its standard format to a vendor contracted with Employer and otherwise acceptable to CHLIC solely for the purposes of such vendor's support of Plan administration functions. Employer agrees that its vendors may not utilize Claims data for any other purpose, including, without limitation, developing products and services, analyzing the Claims data against market benchmarks or CHLIC competitors or adding to a normative database (even if de-identified and/or blinded as to Member and PBM/carrier) for the Employer's or vendor's commercial use. Employer shall be responsible for any use or disclosure of Claims data, or any services provided, by the vendor. Notwithstanding the foregoing, all audits of any pricing guarantees, Rebate-sharing obligations or Claims processing accuracy shall be conducted in accordance with the terms in this Agreement specifically relating to such audits.

(c) De-Identified Data. During and after the term of this Agreement, CHLIC may use Claims, drug, and medical data that has been de-identified in accordance with HIPAA for research, provider evaluation, database maintenance, and other commercial purposes.

This provision shall survive termination or expiration of the Agreement.

5. **Pharmacy Claims Processing Audits**.

(a) Employer may, to the extent specified below and at no additional charge, conduct a claims processing audit of CHLIC's administration of Plan Benefits, once every Plan Year provided that the Agreement has been duly executed by Employer and Employer is current in the payment of all pharmacy claims under the Agreement. New audits shall not be initiated until all parties have agreed that any and all prior pharmacy-related audits are closed. In order to balance the need to adequately support the audit process for all CHLIC clients, with an efficient allocation of resources, employers who choose to audit one or more components of the pharmacy arrangement must do so through a single annual audit.

(b) Claims processing audits shall be subject to the following conditions: (1) the audit may take place while the Agreement is in effect or within one (1) year after the termination or expiration of the Agreement; (2) the initial audit period for a retrospective claims audit shall not exceed the twenty-four (24) months period immediately preceding CHLIC's receipt of the request to audit; (3) Employer shall be responsible for its incurred costs regarding the audit; (4) Employee shall designate, with CHLIC's consent, such consent not to be unreasonably withheld, an independent, third party auditor to conduct the audit (the "Auditor") so long as such Auditor is not engaged in providing services for Employer (including, but not limited to the Auditor's engagement as an expert witness in litigation against CHLIC or its affiliates), or otherwise, that conflict with the scope or independent nature of the

audit (as determined by CHLIC acting reasonably and in good faith), and provided that Employer's Auditor executes a mutually acceptable confidentiality agreement; (5) Employer shall provide to CHLIC at least thirty (30) days prior written notice of its intent to audit, and any request by Employer to permit an Auditor to perform an audit will constitute Employer's direction and authorization to CHLIC to disclose PHI to the Auditor; (6) CHLIC will provide all data as reasonably necessary for Auditor to perform the claims processing audit within thirty (30) days following the latter of the audit kick-off call and the Audit Agreement being fully executed or, when applicable, as otherwise agreed upon by the Parties; (7) following Auditor's initial review of the claims, Auditor will provide CHLIC in writing with all suspected categories of claim errors, if any, together with an electronic data file, in a mutually agreed upon format, containing up to three-hundred (300) claims, so that CHLIC may evaluate and investigate Auditor's suspected errors; (8) CHLIC will respond to the suspected errors within sixty (60) days from CHLIC's receipt of such written findings; (9) upon receipt and review of CHLIC's responses, Auditor will provide CHLIC with a written report of Auditor's findings and recommendations before or at the same time such audit report is provided to Employer; (10) CHLIC will respond to the audit report within thirty (30) days of the issuance of Auditor's report; (11) once both Parties have accepted the audit results, the audit shall be considered closed and final; (12) to the extent the mutually accepted audit results demonstrate claims errors, CHLIC will reprocess the claims and make corresponding adjustments to Employer; (13) CHLIC's obligations to respond within the designated periods above is conditioned upon a good faith and cooperative working relationship between Employer and/or its Auditor and CHLIC, including but not limited to no new or additional issues that appear in the final report that were not otherwise provided to CHLIC during the preliminary review of suspected errors.

This provision shall survive termination or expiration of the Agreement.

6. **Pharmacy Rebate Audits**.

(a) Employer may, to the extent specified below, in accordance with the following requirements, and at no additional charge, audit CHLIC's payment of Rebates provided that the Agreement has been duly executed by Employer and Employer is current in the payment of all pharmacy claims under the Agreement. Any Rebate audit shall occur following CHLIC's issuance of the annual financial reconciliation to Employer once in each twelve (12) month period. New audits shall not be initiated until all parties have agreed that all prior pharmacy-related audits are closed. In order to balance the need to adequately support the audit process for all CHLIC clients, with an efficient allocation of resources, employers who desire to audit one or more components of the pharmacy arrangement must do so through a single annual audit.

(b) Rebate audits shall be subject to the following conditions: (1) Employer and CHLIC shall agree on a mutually acceptable, independent, third-party auditor to conduct the audit, including the individual(s) employed or contracted to perform the audit to ensure that they shall not have a conflict of interest that could reasonably diminish their impartiality (the "Auditor"); (2) Employer shall be responsible for its incurred costs regarding the audit; (3) Employer shall provide CHLIC with at least forty-five (45) days prior written notice of its intent to audit; (4) a mutually agreed upon nondisclosure/nonuse agreement for rebate audits

shall be executed by Employer, the Auditor and CHLIC; (5) the scope of records to be audited as being necessary to determine CHLIC's compliance with its contractual Rebate payment obligations under the Agreement shall be as mutually agreed upon by the Auditor and CHLIC; (6) the Auditor may select for audit purposes the records of up to five (5) manufacturers for two (2) calendar quarters from the last reconciled plan year immediately preceding the written request to audit; (7) the audit shall be conducted at a mutually acceptable time during regular business hours at CHLIC's offices where such records are located; (8) records shall not be removed or photocopied without CHLIC's express written consent; (9) for the sole purpose of confirming compliance with the audit Confidentiality Agreement, Auditor will first submit in draft to CHLIC, and prior to submission to Employer, its Rebate audit report, so that CHLIC can confirm that no terms of the applicable rebate agreements which are confidential, are disclosed in the audit report; (10) the Auditor shall provide its final audit report to CHLIC and Employer at the same time; and (11) the Auditor may disclose the aggregate amount of Rebates due Employer but no other details of CHLIC's rebate contracts of which the Auditor is apprised, if any.

This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT - FUNDING AND PAYMENT OF CLAIMS; CHARGES

1. **Funding and Payment of Claims**. With respect to Pharmacy Benefits, (1) CHLIC may withdraw funds from the Bank Account for the purposes specified in Section 3 of the Agreement five times per month, and (2) any recovered overpayments shall be credited to Employer via a line item on its invoice, less the fee set forth on the Schedule of Financial Charges.

2. **Retroactive Member Changes and Terminations**. Notwithstanding anything in the Agreement to the contrary, Employer shall remain responsible for all charges and Bank Account Payments incurred or charged through the date CHLIC processed Employer's notice of a retroactive change or termination of a Member's enrollment in the Plan. Notwithstanding anything to the contrary in Section 4.c. of the Agreement, with respect to Pharmacy Benefits, CHLIC generally will implement eligibility updates received from Employer that adhere to CHLIC's standard electronic format as soon as reasonably practicable following receipt of such updates.

PHARMACY BENEFIT MANAGEMENT - FIDUCIARY ACKNOWLEDGMENTS

CHLIC offers pharmacy benefit management services for consideration by Employer and other entities. The general parameters of such services and the supporting systems have been developed by CHLIC as part of CHLIC's administration of its general business as a pharmacy benefit manager for entities that sponsor group health plans. The Parties have negotiated the terms of this Agreement in an arm's-length fashion. Except to the extent CHLIC conducts the final level of internal appeal as set forth in Section 2.c of the Agreement, the Parties assert that neither Party intends that CHLIC shall be a fiduciary with respect to Pharmacy Benefits for either ERISA (if applicable) or state law purposes, and neither Party shall name CHLIC or any of its affiliates as a "plan fiduciary" with respect to its management of Pharmacy Benefits. Employer acknowledges and agrees that CHLIC (i) does not have discretionary authority or control respecting management of the Pharmacy Benefits, and (ii) does not exercise any authority or control respecting management or disposition of the assets relating to Pharmacy Benefits or of Employer. Rather, Employer retains all such authority and control. The Parties agree that, upon reasonable notice, CHLIC shall have the right to terminate

its Pharmacy Benefit services under this Agreement to any Plan and/or Members located in a state that requires a pharmacy benefit manager to be a fiduciary to Employer, the Plan or a Member.

This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT - FINANCIAL ARRANGEMENTS

1. **General**. CHLIC contracts with its PBM affiliate for the provision of pharmacy benefit services and financial arrangements. As such, CHLIC or its PBM affiliate, directly or indirectly contract on their own accounts with Retail Pharmacies and Cigna Home Delivery Pharmacy to dispense covered pharmaceutical products to Employer's Members, and not on behalf of, or for the benefit of, Employer or the Plan; accordingly, any discounts or other remuneration CHLIC or its PBM affiliate earns under an arrangement with a Retail Pharmacy or Cigna Home Delivery Pharmacy are obtained for, and inure to, the sole and exclusive benefit of CHLIC or its PBM affiliate, and not the Employer or the Plan. Amounts paid by CHLIC or its PBM affiliate or by the PBM affiliate for Retail Pharmacy or Cigna Home Delivery Pharmacy for Brand Drug, Generic Drug, or Specialty Drug Claims may or may not be equal to the amount charged to Employer and/or Member. If the amount paid by Employer and/or Member does not equal the amount paid by CHLIC or its PBM affiliate or by the PBM affiliate to a particular pharmacy, CHLIC and its PBM affiliate will absorb or retain such difference. CHLIC may directly or indirectly contract for Rebates, Manufacturer Administrative Fees, and other remuneration on its own behalf and for its own benefit, and not on behalf of Employer or the Plan. As an example of other remuneration other than Rebates or Manufacturer Administrative Fees that CHLIC may earn, CHLIC may also directly or indirectly earn from pharmaceutical manufacturers remuneration in connection with value payments and/or services that CHLIC provides to Employer ("Value-Based Payments"). Notwithstanding anything in this Agreement to the contrary, any Value-Based Payments earned by CHLIC are separate and apart from any Rebates or Manufacturer Administrative Fees that CHLIC directly or indirectly earns from pharmaceutical manufacturers, and CHLIC may retain any Value-Based Payments it earns. As examples of the value payments and/or services that CHLIC may provide to Employer in connection with Value-Based Payments that CHLIC may earn, CHLIC may provide care management or other services to Employer and/or remit to Employer monetary credits if Members discontinue therapy on certain pharmaceutical products. Information regarding any services, and/or monetary credits or other financial value, for which Employer may be eligible with respect to specific pharmaceutical products or therapeutic classes/conditions, including the products for which monetary credits or other financial value may be available to Employer, the amount of that value, and other payment terms, is available upon request. Any value payments and/or services provided by CHLIC to Employer are subject to change or termination by CHLIC as the value program(s), if any, offered by CHLIC change(s) or terminate(s). Accordingly, CHLIC retains all right, title and interest to any and all actual Rebates, Manufacturer Administrative Fees, Value-Based Payments, and other remuneration directly or indirectly received from manufacturers. CHLIC may provide Employer amounts equal to all or some portion of the Rebate and Manufacturer Administrative Fee amounts, or other financial value generated in connection with any value program(s), allocated to Employer, if any, and as specified on the Schedule of Financial Charges, from CHLIC's general assets (neither Employer, its Members, nor Employer's Plan retains any beneficial or proprietary interest in CHLIC's general assets). Rebate and Manufacturer Administrative Fee amounts received vary based on factors including, without

limitation, Employer-specific utilization, the volume of utilization as well as Formulary position applicable to the drug or supplies, and adherence to various formulary management controls, benefit design requirements, and Claims volume. Employer acknowledges and agrees that neither it, its Members nor its Plan will have a right to interest on, or the time value of, any Claim payments charged by CHLIC to Employer or any Rebate, Manufacturer Administrative Fee or other payments received by CHLIC during the collection period of moneys payable under this section, if any, and that CHLIC shall retain any such remuneration. For purposes of this provision, the term CHLIC shall also include and mean CHLIC's PBM affiliate, Express Scripts, Inc.

2. **Affiliates**. Cigna Home Delivery Pharmacy may maintain product purchase discount arrangements and/or fee-for-service arrangements with pharmaceutical manufacturers and wholesale distributors in its capacity as a mail service and/or specialty pharmacy. Cigna Home Delivery Pharmacy may contract for these arrangements on its own account in support of its pharmacy operations, and not on behalf of, or for the benefit of, Employer or the Plan. Accordingly, Cigna Home Delivery Pharmacy retains the sole and exclusive benefit of any difference between its acquisition cost for a pharmaceutical product and the amount charged to Employer under this Agreement. Further these arrangements relate to services provided outside of this Agreement and other pharmacy benefit management arrangements and may be entered into without regard to whether a specific drug is on one of the formularies that CHLIC offers to entities that sponsor group health plans. Discounts and fee-for-service payments received by Cigna Home Delivery Pharmacy are not part of the pharmacy benefit management formulary rebates or associated administrative fees or charges paid to CHLIC in connection with CHLIC's pharmacy benefit management formulary rebate programs.

This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT - OBLIGATIONS UPON TERMINATION

Upon notice of termination of this Agreement, the following provisions shall apply with respect to Pharmacy Benefits:

a) Employer shall notify Members at least thirty (30) days prior to the termination of the Agreement becoming effective of any transition to a successor pharmacy benefit manager.

b) If mutually agreed upon by CHLIC and Employer, CHLIC shall provide services following termination of the Agreement at CHLIC's then-prevailing rate. Such services, if any, shall be determined by mutual agreement of CHLIC and Employer in advance of the termination of the Agreement becoming effective.

c) Upon request by Employer and subject to execution of a nondisclosure agreement acceptable to CHLIC, CHLIC shall transition Claims files and/or history to the pharmacy benefit manager or other third party specified by Employer and otherwise acceptable to CHLIC. Any disclosure of Claims files and/or history shall be limited to the information the successor pharmacy benefit manager or other third party needs to implement or administer Employer's pharmacy benefits. CHLIC shall not be required to

directly or indirectly release, and Employer shall not release, PBM Proprietary Information to any such third party.

d) Upon termination of the Agreement for any reason, the Parties shall handle Confidential Information, PBM Proprietary Information and Protected Health Information (as defined in the Business Associate Agreement attached as Exhibit D) pursuant to the terms of the Agreement.

e) In the event that CHLIC terminates the Agreement pursuant to Section 1.v of the Agreement, CHLIC shall have no further obligation following the date of such termination to pay Employer any Rebates, or any other amount that may otherwise be payable by CHLIC to Employer.

This provision shall survive termination or expiration of the Agreement.

PHARMACY BENEFIT MANAGEMENT - CONFIDENTIALITY

1. **General**. Employer acknowledges and agrees that CHLIC's PBM Proprietary Information constitutes competitively sensitive trade secrets, and that its misuse or mis-disclosure could result in material financial and legal loss or liability to CHLIC, its affiliates and their respective subcontractors. CHLIC shall not be required to disclose PBM Proprietary Information to Employer except to the extent necessary for Employer to exercise any audit rights expressly provided hereunder or perform other Plan administration functions. If CHLIC discloses PBM Proprietary Information to Employer, or, if CHLIC consents, to the Employer's vendor or designee, CHLIC may require Employer, or its vendor or designee, to execute a non-disclosure agreement specifically relating to the requested PBM Proprietary Information. Employer agrees that it and its vendors may not utilize PBM Proprietary Information for any purpose other than performing Plan administration functions, including, without limitation, developing products and services, de-identifying, blinding or analyzing the PBM Proprietary Information against market benchmarks or CHLIC competitors or adding to a normative database for the Employer's, or vendor's or designee's, commercial use. For the purposes of clarity, information shall not cease to qualify as PBM Proprietary Information if Employer or its vendor or designee de-identifies and/or blinds the PBM Proprietary Information such that the information cannot be traced or identified to a Member or CHLIC, its affiliates or their respective subcontractors. Employer shall be solely responsible for any disclosure of PBM Proprietary Information by CHLIC to Employer or its vendor or designee, or any subsequent use or disclosure by Employer or its vendor or designee, or services provided by the same. Notwithstanding anything herein to the contrary, in no event will CHLIC be required to disclose to Employer, or its vendor or designee, information related to, or including, its pharmacy network agreements, vendor agreements or pharmaceutical manufacturer agreements.

2. **Compelled Disclosures**. If at any time Employer, or its vendor or designee, is required by law, court order or other valid legal process to disclose any Confidential Information, it will promptly notify CHLIC prior to any such compelled disclosure and, upon request, cooperate with CHLIC in seeking a protective order or other available relief to contest or limit the scope of such compelled disclosure.

3. **Return or Destruction of Information**. At any time upon CHLIC's request or upon expiration or termination of this Appendix A or the Agreement, whichever occurs first, Employer will, at CHLIC's option, promptly deliver, or, as the case may be, compel its vendor or designee to deliver, to CHLIC all PBM Proprietary Information or other Confidential Information (or such portion thereof as requested) and not retain any copies in whole or in part of such PBM Proprietary Information or other Confidential Information, or securely destroy or dispose, or, as the case may be, compel its vendor or designee to destroy or dispose, of those portions of documents and other materials in any form, including electronic form, prepared by or received by the Employer or its vendor or designee, that contain or reflect such PBM Proprietary Information or other Confidential Information. Employer, or its vendor or designee, shall certify such return and destruction, as the case may be, to CHLIC.

Appendix B - Cigna Home Delivery Pharmacy Specialty Drug List

THIS SPECIALTY DRUG LIST IS CONFIDENTIAL, PROPRIETARY INFORMATION OF CHLIC. IT IS PROVIDED SOLELY FOR EMPLOYER'S PLAN ADMINISTRATION PURPOSES. RE-DISCLOSURE IS STRICTLY PROHIBITED EXCEPT AS OTHERWISE PROVIDED BY APPLICABLE LAW. CHLIC RESERVES ALL LEGAL RIGHTS AND REMEDIES TO ENFORCE THESE PROHIBITIONS ON USE AND DISCLOSURE.

The Specialty Drug List shall be provided separately to Employer, and is hereby incorporated into the Agreement by reference, inclusive of any changes made subsequent to CHLIC's initial issuance of the Specialty Drug List to Employer to the pharmaceutical products included on the Specialty Drug List or the discounts pertaining to such pharmaceutical products. Upon Employer's request on or after the Effective Date, CHLIC shall provide to Employer an updated Specialty Drug List.

Currently Marketed Specialty Drugs on this Specialty Drug List. The discounts in this Specialty Drug List are the discounts that will be adjudicated in CHLIC's claim processing system for the drug indicated when dispensed by Cigna Home Delivery Pharmacy, subject to all of the following.

- The discounts in this Specialty Drug List are based on the terms and design of the Pharmacy Benefit that Employer has adopted and disclosed to CHLIC. Accordingly, if Employer fails to disclose to CHLIC, for example, that it uses or intends to use a consumer-driven health plan, a major cost-sharing program, or a utilization management program promoting generic or OTC drugs over brand drugs, CHLIC may adjust the discounts as it reasonably deems necessary to preserve the economic value or benefit of this Agreement as CHLIC anticipated based on the terms and design of the Pharmacy Benefit previously disclosed to CHLIC and prior to CHLIC's discovery of the Pharmacy Benefit design feature that materially impacts CHLIC's discounts in this Specialty Drug List.

- The discounts in this Specialty Drug List shall not apply to Compound Drug claims, Claims that process at U&C, direct member reimbursement (DMR) Claims, and drugs adjudicated under the medical benefit.

- Any or all of the discounts in this Specialty Drug List may be adjusted by CHLIC to the extent reasonably necessary to preserve the economic value of this Agreement as it existed immediately prior to the occurrence of any of the following events: (a) there are any significant changes in the composition of CHLIC's pharmacy network or in CHLIC's pharmacy network contract compensation rates, or the structure of the pharmacy stores/chains/vendors that are contracted with CHLIC, including but not limited to disruption in the retail pharmacy delivery model, or bankruptcy of a chain pharmacy; or (b) there is a change in government laws or regulations which has a significant impact on pharmacy claim costs; or (c) any material manufacturer-rebate contracts with or for the benefit of CHLIC are terminated or modified in whole or in part; or (d) there is any legal action or Law that materially affects or could materially affect the manner in which CHLIC's rebate program is administered or an existing Law is interpreted so as to materially affect or potentially have a material effect on CHLIC's administration of the Pharmacy Benefit; (e) there is a material change in the Plan or the Plan's Pharmacy Benefit that is initiated by Employer which impacts CHLIC's costs or (f) a major change in market conditions affecting the pharmaceutical or pharmacy benefit management market, a drug shortage in the market, an issue involving the safety of the drug supply, or similar market situation.

New-to-Market Specialty Products. Specialty Drug Claims, excluding Limited Distribution Drugs and

Exclusive Distribution Drugs, that are for new-to-market drugs will have a minimum market-introduction guaranteed discount of 11.45% off the drug's AWP.

"Limited Distribution Drug" or "Exclusive Distribution Drug" shall mean a Specialty Drug that is not generally available from most or all pharmacies and is restricted to select pharmacies as determined by a pharmaceutical manufacturer. The list of Limited Distribution Drugs and Exclusive Distribution Drugs will be maintained by CHLIC.

IN WITNESS WHEREOF, the parties have executed this Administrative Services Only Agreement "Amendment No. 6" on the date set forth below.

CITY OF SANTA FE:

_____

ALAN WEBBER, MAYOR

DATE:_____

CONTRACTOR:
CIGNA

Aimee E. Burnham
Aimee E. Burnham (Dec 7, 2022 10:56 EST)

NAME & TITLE

DATE: Dec 7, 2022

ATTEST:

_____

KRISTINE BUSTOS MIHELCIC, CITY CLERK

CITY ATTORNEY'S OFFICE:

Marcos Martinez
Marcos Martinez (Nov 3, 2022 16:36 MDT)

SENIOR ASSISTANT CITY ATTORNEY

APPROVED FOR FINANCES:

_____

EMILY OSTER, FINANCE DIRECTOR

6050237.510300, 6050238
Business Unit Line Item AH

City of Santa Fe

Treasury Department
200 Lincoln Ave.
Santa Fe, New Mexico 87504-0909
505-955-6551

BUSINESS REGISTRATION

Business Name: CIGNA HEALTH AND LIFE INSURANCE COMPANY
DBA: CIGNA

Business Location: 900 COLLEGE GROVE RD
BLOOMFIELD, CT 06002

CRS Number: 03269468007

Owner: CIGNA HEALTH AND LIFE INSURANCE COMPANY

License Number: 233870

License Type: Business License - Renewable

Issued Date: November 15, 2022

Classification: Out of Jurisdiction Business License

Expiration Date: November 15, 2023

Fees Paid: $10.00

CIGNA HEALTH AND LIFE INSURANCE COMPANY
900 COTTAGE GROVE RD
BLOOMFIELD, CT 06002

THIS IS NOT A CONSTRUCTION PERMIT OR SIGN PERMIT. APPROPRIATE PERMITS MUST BE OBTAINED FROM THE CITY OF SANTA FE BUILDING PERMIT DIVISION PRIOR TO COMMENCEMENT OF ANY CONSTRUCTION OR THE INSTALLATION OF ANY EXTERIOR SIGN.

THIS REGISTRATION/LICENSE IS NOT TRANSFERRABLE TO OTHER BUSINESSES OR PREMISES.

TO BE POSTED IN A CONSPICUOUS PLACE

CERTIFICATE OF LIABILITY INSURANCE

DATE(MM/DD/YYYY) 03/25/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Aon Risk Services Central, Inc. Philadelphia PA Office 100 North 18th Street 15th Floor Philadelphia PA 19103 USA	CONTACT NAME: PHONE (A.C. No. Ext): (866) 283-7122	FAX (A/C. No.): (800) 363-0105
	E-MAIL ADDRESS:	

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A:	Lexington Insurance Company	19437
INSURER B:		
INSURER C:		
INSURER D:		
INSURER E:		
INSURER F:		

INSURED
Cigna Corporation Et Al
900 Cottage Grove Road
Bloomfield CT 06002 USA

COVERAGES **CERTIFICATE NUMBER:** 570092175974 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS. **Limits shown are as requested**

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	
							MED EXP (Any one person)	
							PERSONAL & ADV INJURY	
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	
	☐ OTHER							
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	
	☐ ANY AUTO						BODILY INJURY (Per person)	
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	
	☐ DED ☐ RETENTION							
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTHER	
	ANY PROPRIETOR / PARTNER / EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ N / A						E.L. EACH ACCIDENT	
	(Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE-EA EMPLOYEE	
							E.L. DISEASE-POLICY LIMIT	
A	HealthCare Prov			11466384 HealthCare Prof Liab	03/30/2022	03/30/2023	Per Claim Agg-Claims Made	$1,000,000 $3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
See attached list of additional Named Insureds.

CERTIFICATE HOLDER

City of Santa Fe
Attn: Colleen Higgins-Vigil
200 Lincoln Ave
Santa Fe NM 87501-1904 USA

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Aon Risk Services Central Inc.

Holder Identifier :

Certificate No : 570092175974

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City of Santa Fe New Mexico
Memorandum

DATE: **November 10, 2022**

TO: **Mayor Webber and Governing Body**
Finance Committee
Economic Development Advisory Committee
Public Works Committee

VIA: **Emily Oster, Finance Department Director**
JoAnn Salazar, Supervisor - Procurement Office
Kyra Ochoa, Director, Community Health and Safety KO

FROM: **Rich Brown, Director, Community and Economic Development**
Julie Sanchez, Director, Youth and Family Services Division jjs

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ITEM AND ISSUE:

Request for Approval of American Rescue Plan Act (ARPA) Recover Funds Subrecipient Contract with the Santa Fe Public Schools, in the total amount of $797,600, for work-based learning and paid internship programs under the US Treasury Guidelines: *1.11 Community Violence Intervention and 2.10 Assistance to Unemployed or Underemployed Workers* – to respond to the COVID-19 public health emergency or its negative economic impacts. (Rich Brown, rdbrown@santafenm.gov, (505) 955-6625 and Julie Sanchez, jjsanchez@santafenm.gov (505) 955-6678)

BACKGROUND AND SUMMARY:

The City of Santa Fe is a recipient of a State and Local Fiscal Recovery Funds (SLFRF) award. The Office of Economic Development in partnership with the Youth and Family Services Division is administering $797,600 of American Rescue Plan Act (ARPA) funding for, mentorship and job training, $639,267 is being allocated from Economic Development to the Santa Fe Public Schools toward the operation of a work-based learning, paid internship program geared towards public high school juniors, seniors, recent graduates, and unemployed graduates. The Youth and Family Services Division is contributing approximately $158,333 to support students who are at high risk for initiating violence.

In partnership with the Santa Fe Public Schools, the City will create a Youth Corps jobs training and workforce development program. The Youth Corps is a professional development, paid internship programs for youth interested in arts-based, trades and diversified industries leadership opportunities. Interested rising high school juniors, seniors and recent graduates living in the Santa Fe will be eligible to apply. The Youth Corps workforce development program

strives to provide Santa Fe's youth a safe and meaningful opportunity to develop their skills, build a professional network, and prepare for the future.

The ARPA funds will provide the funding required for the school's operations and services, including business outreach, student mentoring, soft and life skills training, student internship placement, paid internships, measurement and required impact reports for a period from November 2022 through June 30, 2024.

CONTRACT NUMBER:
The FY23 Munis contract number is 3203770.

PROJECT LEDGER:
The project ledger number is ECD222400C and COM222400G.

FUNDING SOURCE:
The funding source is:
Fund Name/Number: Community Development Fund/ 240
Munis Org Name/Number: Economic Development Programs/2402800
Munis Object Name/Number: Grants and Services/510340
Total: $639,267

And

Fund Name/Number: Human Services Fund/ 240
Munis Org Name/Number: Health and Human Services/2400122
Munis Object Name/Number: Grants and Services/510340
Total: $158,333

ACTION REQUESTED:
The Office of Economic Development and Community Health and Safety Department respectfully requests your review and approval.

Signature: Richard Brown

Email: rdbrown@santafenm.gov

Signature: Kyra Ochoa (Nov 10, 2022 18:08 MST)

Email: krochoa@santafenm.gov

CITY OF SANTA FE PROCUREMENT CHECKLIST

Contractor Name: Santa Fe Public Schools

Procurement Title: Santa Fe Public Schools for Work-Based Learning Program

Procurement Method: State Price Agreement ☐ Cooperative ☐ Sole Source ☐ Other ☐

Exempt ☑ Request For Proposal (RFP) ☐ Invitation To Bid (ITB) ☐ Contract under 60K ☐ Contract over 60K ☐

Department Requesting Community Health & Safety Staff Name Julie Sanchez

Procurement Requirements:

A procurement file shall be maintained for all contracts, regardless of the method of procurement. The procurement file shall contain the basis on which the award is made, all submitted bids, all evaluation materials, score sheets, quotations and all other documentation related to or prepared in conjunction with evaluation, negotiation, and the award process. The procurement shall contain a written determination from the Requesting Department, signed by the purchasing officer, setting forth the reasoning for the contract award decision before submitting to the Committees.

REQUIRED DOCUMENTS FOR APPROVAL BY PURCHASING*

YES	N/A	
☑	☐	Approved Procurement Checklist (by Purchasing)
☑	☐	Memo addressed to City Manager (under 60K) Committees/City Council (over 60K)
☐	☑	State Price Agreement
☐	☑	RFP
☐	☑	Evaluation Committee Report
☐	☑	ITB
☐	☑	Bib Tab
☐	☑	Quotes (3 valid current quotes)
☑	☐	Cooperative Agreement
☐	☑	Sole Source Request and Determination Form
☐	☑	Contractors Exempt Letter
☑	☐	Purchasing Officers approval for exempt procurement
☐	☑	BAR
☐	☑	FIR
☑	☐	Executed Contract, Agreement or Amendment
☐	☑	Current Business Registration and CRS numbers on contract or agreement
☑	☐	Summary of Contracts and Agreements form
☑	☐	Certificate of Insurance
☐	☑	All documentation presented to Committees
☐	☑	Other:

Julie Sanchez	Youth and Families Services	Division Director	11/10/2022
Department Rep Printed Name (attesting that all information included)		Title	Date
JoAnn Lovato JoAnn Lovato (Nov 18, 2022 14:13 MST)		Contracts Supervisor	Nov 18, 2022
Purchasing Officer (attesting that all information is reviewed)		Title	Date
ITT Representative (attesting that all information is reviewed)		Title	Date

Include all other substantive documents and records of communication that pertain to the procurement and contract.

City of Santa Fe

Real Estate Summary of Contracts, Agreements, Amendments & Leases

Section to be completed by department

1. Munis Contract # 3203770

Contractor: Santa Fe Public Schools

Description: Contract between the City of Santa Fe and Santa Fe Public Schools for Work-Based Learning Program

Contract [◉] Agreement [ ] Lease / Rent [ ] Amendment [ ]

Term Start Date: 11/01/2022 Term End Date: 06/30/2024

[ ] Approved by Council Date: _____

Contract / Lease: Professional Service Contract

Amendment # _____ to the Original Contract / Lease # _____

Increase/(Decrease) Amount $ _____

Extend Termination Date to: _____

[ ] Approved by Council Date: _____

Amendment is for:

2. **HISTORY of Contract, Amendments & Lease / Rent - Please Elaborate** (option: attach spreadsheet if multiple amendments)

3. **Procurement History:**

JoAnn Lovato
JoAnn Lovato (Nov 18, 2022 14:13 MST)

Purchasing Officer Review: Nov 18, 2022 Date:

Comment & Exceptions: 13-1-98 # A Exemption approved

4. **Funding Source:** Fund 240 **Org / Object:** 2402800/510340-2400122/510400

Andy Hopkins
Andy Hopkins (Nov 16, 2022 12:49 MST)

Budget Officer Approval: Nov 16, 2022 Date:

Comment & Exceptions: ARPA Ledger Codes: COM222400G / ECD222400C

Staff Contact who completed this form: Melissa Perea Phone # (505) 955-6826

Email: maperea@santafenm.gov

To be recorded by City Clerk:
Clerk # _____
Date of Execution: _____

ITT Representative (attesting that all information is reviewed) Title Date

Item# _____
Munis Contract# 3203770

RECOVERY FUNDS SUBRECIPIENT
CONTRACT BETWEEN CITY OF SANTA FE AND THE SANTA FE PUBLIC SCHOOLS FOR WORK-BASED LEARNING PROGRAM

THIS AGREEMENT is made and entered into by and between the City of Santa Fe, herein after referred to as the "City", and the Santa Fe Public Schools herein after referred to as the "Contractor."

RECITALS

WHEREAS, the City, as a recipient of a State and Local Fiscal Recovery Funds (SLFRF) award, has substantial discretion to use the award funds in the ways that best suit the needs of the City if such use fits into one of the following four statutory categories:

1. To respond to the COVID-19 public health emergency or its negative economic impacts;
2. To respond to workers performing essential work during the COVID-19 public health emergency by providing premium pay to eligible workers of the recipient that are performing such essential work, or by providing grants to eligible employers that have eligible workers who perform essential work;
3. For the provision of government services, to the extent of the reduction in revenue of such recipient due to the COVID–19 public health emergency, relative to revenues collected in the most recent full fiscal year of the recipient prior to the emergency; or
4. To make necessary investments in water, sewer, or broadband infrastructure;

WHEREAS this Contract falls within the first statutory category;

WHEREAS, recipients are responsible for ensuring that any procurement using SLFRF funds, or payments under procurement contracts using such funds, Coronavirus State and Local Fiscal Recovery Funds Compliance and Reporting Guidance are consistent with the procurement standards set forth in the Uniform Guidance at 2 CFR 200.317 through 2 CFR 200.327, as applicable;

WHEREAS, the Uniform Guidance establishes in 2 CFR 200.319 that all procurement transactions for property or services must be conducted in a manner providing full and open competition, consistent with standards outlined in 2 CFR 200.320, which allows for non-competitive procurements only in circumstances where at least one of the conditions below is true: the item is below the micro-purchase threshold; the item is only available from a single source; the public exigency or emergency will not permit a delay from publicizing a competitive solicitation; or after solicitation of a number of sources, competition is determined inadequate; and

WHEREAS, Subrecipients under the SLFRF program are entities that receive a subaward from a recipient to carry out the purposes (program or project) of the SLFRF award on behalf of the recipient.

IT IS MUTUALLY AGREED BETWEEN THE PARTIES:

1. **Definitions**

A. "Products and Services Schedule" refers to the complete list of products and services offered under this Agreement and the price for each. Product and service descriptions may be amended with the prior approval of the Agreement Administrator. New products and services shall not be added to the Products and Services Schedule.

B. The Agreement Administrator is the person selected by the City as the contact for this agreement.

C. "Business Hours" means 8:00 a.m. to 5:00 p.m. Mountain Time.

D. "Subrecipient" means an entity, usually but not limited to non–Federal entities, that receives a subaward from a pass-through entity to carry out part of a Federal award; but does not include an individual that is a beneficiary of such award. 2 C.F.R. § 200.1

E. "You" and "your" refers to the Santa Fe Public Schools. "We," "us" or "our" refers to the City and whose accounts are created under this Agreement.

2. **Scope of Work**

A. The Contractor shall perform the work as outlined in Exhibit A, attached hereto and incorporated herein by reference.

B. Performance measures as outlined in Exhibit B.

C. The attached performance measurements are preliminary and are an estimated goal. The Agreement Administrator and Contractor will re-evaluate and agree upon performance measurements, on a quarterly basis to align realistic measures for the following year.

D. The Contractor will recruit and offer all Work-Based Learning internship opportunities to students that are interested in the internship program as categorized in the demographic distribution below:

a. Students with one or more disabilities
b. Low-Income Students
c. English Learners
d. Migratory Students
e. Students Experiencing Homelessness
f. American Indian/Alaska Native

g. Black or African American
h. Hispanic/Latino
i. White
j. Two or more races or mixed races

E. The City agrees to provide summer and/or school year internships to SFPS students, based on current capacity needs.

i. The Partner agrees to comply with the Family Educational Rights and Privacy Act ("FERPA") 20 U.S.C. § 1232g; 34 CFR Part 99.

ii. CRIMINAL BACKGROUND CHECK.

For any individual providing services pursuant to the City's explicit or implicit direction or permission, the City shall make one of the following warranties, in compliance with Megan's law and §22-10A-5 NMSA 1978 of the School Personnel Act.

1. By this signature _____, SHALL WARRANT that such individuals will not have unsupervised access to students; OR
2. By this signature _____, SHALL WARRANT that the individual who will have unsupervised access to students has no felony convictions and is not a registered sex offender, as verified by the Partner's:
   a. Performance of an internet search on the individual; and
   b. Completion of a federally recognized fingerprint and background check on the individual no more than five (5) years prior to, and no later than the first business day of, commencement of services under this Agreement.

F. The Santa Fe Public Schools understands that this contract represents a subaward of SLFRF funds, agrees to maintain records to satisfy all compliance requirements for use of SLFRF, and agrees to all reporting requirements for expenditures of SLFRF funds.

3. **Compensation**

Compensation Schedule. The City shall pay to the Contractor based upon fixed prices for each Deliverable, per the schedule outlined in Exhibit A, less retainage, if any, as identified in paragraph D of this Clause.

[For an hourly-rate based contract use the following language:]

A. The City shall pay to the Contractor in full payment for services satisfactorily performed at the rate of **$312,800** from November 2022 to June 2023, then **$484,800** in the years July 2023 to June 2024 (see Exhibit A for breakdown) and then such compensation not to exceed (**$312,800** by June 2023 and **$484,800** by June 2024), excluding gross receipts tax. *The New* Mexico gross receipts tax levied on the amounts payable under this Agreement totaling

($312,800 from November 2022 to June 2023, then $484,800 in the years July 2023 to June 2024) shall be paid by the City to the Contractor. The total amount payable to the Contractor under this Agreement, including gross receipts tax and expenses, shall not exceed ($797,600 from November 2022 to June 2024). All payments under this Agreement are subject to the following provisions.

B. B. Due to the nature of the Contractor's startup costs to implement the program, i.e., paid internships, business outreach, and mentorships, the City will fund the Contractor an advance of $134,057.16 once the agreement is executed by both Parties and a Purchase Order is generated. Furthermore, the remaining funds shall be paid in fixed amounts of $44,685.71 per month (for the first year) upon acceptance of each Deliverable's progress summary, backup of activity, and detailed payment Invoice. The following fiscal year shall be paid in fixed amounts of $40,400 per month. See Exhibit A for breakdown. Payment will be made to the Contractor's designated mailing address. In accordance with Section 13-1-158 NMSA 1978, payment shall be tendered to the Contractor within thirty (30) days of the date of written certification of Acceptance. All Payment Invoices MUST BE received by the City no later than fifteen (15) days after the termination of this Agreement. Payment Invoices received after such date WILL NOT BE PAID.

C. Payment Schedule.

1. November 1, 2022: $134,057.16
2. March 1, 2023: $44,685.71
3. April 1, 2023: $44,685.71
4. May 1, 2023: $44,685.71
5. June 1, 2023: $44,685.71
6. July 1, 2023: $40,400
7. August 1, 2023: $40,400
8. September 1, 2023: $40,400
9. October 1, 2023: $40,400
10. November 1, 2023: $40,400
11. December 1, 2023: $40,400
12. January 1, 2024: $40,400
13. February 1, 2024: $40,400
14. March 1, 2024: $40,400
15. April 1, 2024: $40,400
16. May 1, 2024: $40,400
17. June 1, 2024: $40,400

D. Performance Bond. -Not Applicable. The Parties agree there is no Performance Bond.

E. The Contractor may use SLFRF funds to cover eligible costs incurred during the period that begins on November 1, 2022, and ends on December 31, 2024, if the award funds for

the obligations incurred by December 31, 2024 are expended by December 31, 2026. Costs for projects incurred by the subrecipient prior to March 3, 2021, are not eligible, as provided for in Treasury's final rule. Any funds not obligated or expended for eligible uses by the timelines above must be returned to Treasury, including any unobligated or unexpended funds that have been provided to subrecipients and contractors as part of the award closeout process pursuant to 2 C.F.R. 200.344(d).

4. **Term**

THIS AGREEMENT SHALL NOT BECOME EFFECTIVE UNTIL APPROVED IN WRITING BY THE CITY. This Agreement shall begin on date approved by the City and end on December 31, 2026 In no event will the term exceed the duration allowed by statute, NMSA 1978, § 13-1-150.

5. **Default and Force Majeure**

The City reserves the right to cancel all or any part of any orders placed under this contract without cost to the City, if the Contractor fails to meet the provisions of this contract and, except as otherwise provided herein, to hold the Contractor liable for any excess cost occasioned by the City due to the Contractor's default. The Contractor shall not be liable for any excess costs if failure to perform the order arises out of causes beyond the control and without the fault or negligence of the Contractor; such causes include, but are not restricted to, acts of God or the public enemy, acts of the State or Federal Government, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, unusually severe weather and defaults of sub-contractors due to any of the above, unless the City shall determine that the supplies or services to be furnished by the sub-contractor were obtainable from other sources in sufficient time to permit the Contractor to meet the required delivery scheduled. The rights and remedies of the City provided in this paragraph shall not be exclusive and are in addition to any other rights now being provided by law or under this contract.

6. **Termination**

A. Grounds. The City may terminate this Agreement for convenience or cause, and agrees to pay for work that has already been performed and provide sufficient funds to pay interns for the remainder of the school year if adequate funds have been allocated to the City. The Contractor may only terminate this Agreement based upon the City's uncured, material breach of this Agreement.

B. Notice; City Opportunity to Cure.

1) Except as otherwise provided in Paragraphs 7.A and 17, the City shall give Contractor written notice of termination at least thirty (30) days prior to the intended date of termination.

2) Contractor shall give City written notice of termination at least thirty (30) days prior to the intended date of termination, which notice shall (i) identify all the City's material breaches of this Agreement upon which the termination is based and (ii) state what the

City must do to cure such material breaches. Contractor's notice of termination shall only be effective (i) if the City does not cure all material breaches within the thirty (30) day notice period or (ii) in the case of material breaches that cannot be cured within thirty (30) days, the City does not, within the thirty (30) day notice period, notify the Contractor of its intent to cure and begin with due diligence to cure the material breach.

3) Notwithstanding the foregoing, this Agreement may be terminated immediately upon written notice to the Contractor (i) If the Contractor breaches a of this agreement; ; (ii) if, during the term of this Agreement, the Contractor is suspended or debarred by the City; or (iii) the Agreement is terminated pursuant to Paragraph 16, "Appropriations", of this Agreement.

C. Liability. Except as otherwise expressly allowed or provided under this Agreement, the City's sole liability upon termination shall be to pay for acceptable work performed prior to the Contractor's receipt or issuance of a notice of termination; provided, however, that a notice of termination shall not nullify or otherwise affect either party's liability for pre-termination defaults under or breaches of this Agreement. The Contractor shall submit an invoice for such work within thirty (30) days of receiving or sending the notice of termination. *THIS PROVISION IS NOT EXCLUSIVE AND DOES NOT WAIVE THE CITY'S OTHER LEGAL RIGHTS AND REMEDIES CAUSED BY THE CONTRACTOR'S DEFAULT/BREACH OF THIS AGREEMENT.*

7. Amendment

A. This Agreement shall not be altered, changed or amended except by instrument in writing, pursuant to Paragraph. 2C, or as otherwise amended by the parties hereto and all other required signatories.

B. If the City proposes an amendment to the Agreement to unilaterally reduce funding due to budget or other considerations, the Contractor shall, within thirty (30) days of receipt of the proposed Amendment, have the option to terminate the Agreement, pursuant to the termination provisions as set forth in Paragraph 7 herein, or to agree to the reduced funding.

8. Status of Contractor

The Contractor, and Contractor's agents and employees, are independent Contractors for the City and are not employees of the City. The Contractor, and Contractor's agents and employees, shall not accrue leave, retirement, insurance, bonding, use of City vehicles, or any other benefits afforded to employees of the City as a result of this Agreement. The Contractor acknowledges that all sums received hereunder are personally reportable by the Contractor for income tax purposes, including without limitation, self-employment tax and business income tax. The Contractor agrees not to purport to bind the City unless the Contractor has written authority to do so, and then only within the strict limits of that authority.

9. Assignment

The Contractor shall not assign or transfer any interest in this Agreement or assign any claims for money due or to become due under this Agreement without the prior written approval of the City.

10. **Subcontracting**

The Contractor shall not subcontract any portion of the services to be performed under this Agreement without the prior written approval of the City. No such subcontract shall relieve the primary Contractor from its obligations and liabilities under this Agreement, nor shall any subcontract obligate direct payment from the City.

11. **Non-Collusion**

In signing this Agreement, the Contractor/Contractor certifies the Contractor/Contractor has not, either directly or indirectly, entered into action in restraint of free competitive bidding in connection with this offer submitted to the City.

12. **Inspection of Plant**

The City may inspect, at any reasonable time during Contractor's regular business hours and upon prior written notice, the Contractor's plant or place of business, or any subcontractor's plant or place of business, which is related to the performance of this contract.

13. **Commercial Warranty**

The Contractor agrees that the tangible personal property or services furnished under this Agreement shall be covered by the most favorable commercial warranties the Contractor gives to any customer for such tangible personal property or services, and that the rights and remedies provided herein shall extend to the City and are in addition to and do not limit any rights afforded to the City by any other clause of this order. Contractor agrees not to disclaim warranties of fitness for a particular purpose or merchantability.

14. **Condition of Proposed Items**

Where tangible personal property is a part of this Agreement, all proposed items are to be NEW and of most current production, unless otherwise specified.

15. **Records and Audit**

During the term of this Agreement and for five years thereafter, the Contractor shall maintain detailed records pertaining to the services rendered and products delivered. These records shall be subject to inspection by the City, the State Auditor and other appropriate state and federal authorities. The City shall have the right to audit billings both before and after payment. Payment under this Agreement shall not foreclose the right of the City to recover excessive or illegal payments.

16. **Appropriations**

The terms of this Agreement, and any orders placed under it, are contingent upon sufficient appropriations and authorization being made by the City Council for the performance of this Agreement. If sufficient appropriations and authorization are not made by the legislature, this Agreement, and any orders placed under it, shall terminate upon written notice being given by the City to the Contractor. The City's decision as to whether sufficient appropriations are available shall be accepted by the Contractor and shall be final. If the City proposes an amendment to the Agreement to unilaterally reduce funding, the Contractor shall have the option to terminate the Agreement or to agree to the reduced funding, within thirty (30) days of receipt of the proposed amendment.

That the terms of this Agreement are contingent on sufficient appropriations and authorization being made by the City and the Federal Government for the performance of this Agreement. If, for any reason, sufficient appropriations and authorizations are not made, the Agreement shall terminate upon written notice being given to the Contractor by the District. Such termination shall not result in any claim for damages by the Contractor. The District's decision as to whether sufficient appropriations are available shall be accepted by the Contractor and shall be final.

17. **Release**

The Contractor, upon final payment of the amount due under this Agreement, releases the City, its officers and employees, from all liabilities, claims and obligations whatsoever arising from or under this Agreement. The Contractor agrees not to purport to bind the City, unless the Contractor has express written authority to do so, and then only within the strict limits of that authority.

18. **Confidentiality**

Any confidential information provided to or developed by the Contractor in the performance of this Agreement shall be kept confidential and shall not be made available to any individual or organization by the Contractor without prior written approval by the City or as provided by law.

19. **Conflict of Interest**

A. The Contractor represents and warrants that it presently has no interest and, during the term of this Agreement, shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance or services required under the Agreement. The Contractor shall comply with any applicable provisions of the New Mexico Governmental Conduct Act and the New Mexico Financial Disclosures Act.

B. The Contractor further represents and warrants that it has complied with, and, during the term of this Agreement, will continue to comply with, and that this Agreement complies with all applicable provisions of the Governmental Conduct Act, Chapter 10, Article 16 NMSA 1978.

C. Contractor's representations and warranties in Paragraphs A and B of this Paragraph are material representations of fact upon which the City relied when this Agreement was entered into by the parties. Contractor shall provide immediate written notice to the City if, at any time during the term of this Agreement, Contractor learns that Contractor's representations and warranties in Paragraphs A and B of this Paragraph 20 were erroneous on the effective date of this Agreement or have become erroneous by reason of new or changed circumstances. If it is later determined that Contractor's representations and warranties in Paragraphs A and B of this Paragraph 20 were erroneous on the effective date of this Agreement or have become erroneous by reason of new or changed circumstances, in addition to other remedies available to the City and notwithstanding anything in the Agreement to the contrary, the City may immediately terminate the Agreement.

D. All terms defined in the Governmental Conduct Act have the same meaning in this section.

20. **Scope of Agreement; Merger**

This Agreement incorporates all the agreements, covenants, and understandings between the parties hereto concerning the subject matter hereof, and all such covenants, agreements and understandings have been merged into this written Agreement. No prior agreements or understandings, verbal or otherwise, of the parties or their agents shall be valid or enforceable unless embodied in this Agreement.

21. **Notice**

The Procurement Code, Sections 13-1-28 through 13-1-199 NMSA 1978, imposes civil and criminal penalties for its violation. In addition, the New Mexico criminal statutes impose felony penalties for bribes, gratuities and kickbacks.

22. **Equal Opportunity Compliance**

The Contractor agrees to abide by all federal and state laws, and local Ordinances, pertaining to equal employment opportunity. In accordance with all such laws, rules, and regulations, the Contractor agrees to assure that no person in the United States shall on the grounds of race, religion, color, national origin, ancestry, sex, age, physical or mental handicap, or serious medical condition, spousal affiliation, sexual orientation or gender identity, be excluded from employment with or participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity performed under this Agreement. If Contractor is found not to be in compliance with these requirements during the life of this Agreement, Contractor agrees to take appropriate steps to correct these deficiencies.

23. **Indemnification**

The Contractor shall hold the City and its employees harmless and shall indemnify the City and its employees against any and all claims, suits, actions, liabilities and costs of any kind,

including attorney's fees for personal injury or damage to property arising from the acts or omissions of the Contractor, its agents, officers, employees or subcontractors. The Contractor shall not be liable for any injury or damage as a result of any negligent act or omission committed by the City, its officers or employees.

24. **New Mexico Tort Claims Act**

Any liability incurred by the City of Santa Fe and Santa Fe Public Schools in connection with this Agreement is subject to the immunities and limitations of the New Mexico Tort Claims Act, Section 41-4-1, et. seq. NMSA 1978, as amended. The Parties and their "respective employees" as defined in the New Mexico Tort Claims Act, do not waive sovereign immunity, do not waive any defense and do not waive any limitation of liability pursuant to law. No provision in this Agreement modifies or waives any provision of the New Mexico Tort Claims Act.

25. **Applicable Law**

The laws of the State of New Mexico shall govern this Agreement, without giving effect to its choice of law provisions. Venue shall be proper only in a New Mexico court of competent jurisdiction in accordance with NMSA 1978, § 38-3-2. By execution of this Agreement, Contractor acknowledges and agrees to the jurisdiction of the courts of the State of New Mexico over any and all lawsuits arising under or out of any term of this Agreement.

26. **Limitation of Liability**

The Contractor's liability to the City, for any cause whatsoever shall be limited to the purchase price paid to the Contractor for the products and services that are the subject of the City's, claim. The foregoing limitation does not apply to paragraph 25 of this Agreement or to damages resulting from personal injury caused by the Contractor's negligence.

27. **Incorporation by Reference and Precedence**

If this Agreement has been procured pursuant to a request for proposals, this Agreement is derived from (1) the request for proposal, (including any written clarifications to the request for proposals and any City response to questions); (2) the Contractor's best and final offer; and (3) the Contractor's response to the request for proposals.

In the event of a dispute under this Agreement, applicable documents will be referred to for the purpose of clarification or for additional detail in the following order of precedence: (1) amendments to the Agreement in reverse chronological order; (2) the Agreement, including the scope of work and all terms and conditions thereof; (3) the request for proposals, including attachments thereto and written responses to questions and written clarifications; (4) the Contractor's best and final offer if such has been made and accepted by the City; and (5) the Contractor's response to the request for proposals.

28. **Workers' Compensation**

The Contractor agrees to comply with state laws and rules applicable to workers' compensation benefits for its employees. If the Contractor fails to comply with the Workers' Compensation Act and applicable rules when required to do so, this Agreement may be terminated by the City.

29. **Inspection of Services**

If this contract is for the purchase of services, the following terms shall apply.

A. Services, as used in this Article, include services performed, workmanship, and material furnished or utilized in the performance of services.

B. The Contractor shall provide and maintain an inspection system acceptable to the City covering the services under this Agreement. Complete records of all inspection work performed by the Contractor shall be maintained and made available to the City and for as long thereafter as the Agreement requires. The City has the right to inspect and test all services contemplated under this Agreement to the extent practicable at all times and places during the term of the Agreement. The City shall perform inspections and tests in a manner that will not unduly delay or interfere with Contractor's performance.

C. If the City performs inspections or tests on the premises of the Contractor or a subcontractor, the Contractor shall furnish, and shall require subcontractors to furnish, at no increase in contract price, all reasonable facilities and assistance for the safe and convenient performance of such inspections or tests.

D. If any part of the services do not conform with the requirements of this Agreement, the City may require the Contractor to re-perform the services in conformity with the requirements of this Agreement at no increase in contract amount. When the defects in services cannot be corrected by re-performance, the City may:

(1) require the Contractor to take necessary action(s) to ensure that future performance conforms to the requirements of this Agreement; and

(2) reduce the contract price to reflect the reduced value of the services performed.

E. If the Contractor fails to promptly re-perform the services or to take the necessary action(s) to ensure future performance in conformity with the requirements of this Agreement, the City may:

(1) by contract or otherwise, perform the services and charge to the Contractor any cost incurred by the City that is directly related to the performance of such service; or

(2) terminate the contract for default.

30. **Insurance**

If the services contemplated under this Agreement will be performed on or in City facilities or property, Contractor shall maintain in force during the entire term of this Agreement, the following insurance coverage(s), naming the City as additional insured.

A. **Commercial General Liability** insurance shall be written on an occurrence basis and be a broad as ISO Form CG 00 01 with limits not less than $2,000,000 per occurrence and $2,000,000 in the aggregate for claims against bodily injury, personal and advertising injury, and property damage. Said policy shall include broad form Contractual Liability coverage and be endorsed to name the City of Santa Fe their officials, officers, employees, and agents as additional insureds.

B. **Broader Coverage and Limits.** The insurance requirements under this Agreement shall be the greater of (1) the minimum coverage and limits specified in this Agreement, or (2) the broader coverage and maximum limits of coverage of any insurance policy or proceeds available to the Named Insured. It is agreed that these insurance requirements shall not in any way act to reduce coverage that is broader or that includes higher limits than the minimums required herein. No representation is made that the minimum insurance requirements of this Agreement are sufficient to cover the obligations of Contractor hereunder.

C. Contractor shall maintain the above insurance for the term of this Agreement and name the City as an additional insured and provide for 30 days cancellation notice on any Certificate of Insurance form furnished by Contractor. Such certificate shall also specifically state the coverage provided under the policy is primary over any other valid and collectible insurance and provide a waiver of subrogation.

31. **Impracticality of Performance**

A party shall be excused from performance under this Agreement for any period that the party is prevented from performing as a result of an act of God, strike, war, civil disturbance, epidemic, or court order, provided that the party has prudently and promptly acted to take any and all steps that are within the party's control to ensure performance. Subject to this provision, such non-performance shall not be deemed a default or a ground for termination.

32. **Invalid Term or Condition**

If any term or condition of this Agreement shall be held invalid or unenforceable, the remainder of this Agreement shall not be affected and shall be valid and enforceable.

33. **Enforcement of Agreement**

A party's failure to require strict performance of any provision of this Agreement shall not
waive or diminish that party's right thereafter to demand strict compliance with that or any other provision. No waiver by a party of any of its rights under this Agreement shall be effective unless express and in writing, and no effective waiver by a party of any of its rights shall be effective to waive any other rights.

34. **Disclosure Regarding Responsibility**

A. Any prospective Contractor and any of its Principals who enter into a contract greater than sixty thousand dollars ($60,000.00) with any City for professional services, tangible personal property, services or construction agrees to disclose whether the Contractor, or any principal of the Contractor's company is presently debarred, suspended, proposed for debarment, or declared ineligible for award of contract by any federal entity, state agency or local public body.

B. Principal, for the purpose of this disclosure, means an officer, director, owner, partner, or
a person having primary management or supervisory responsibilities within a business entity or related entities.

C. The Contractor shall provide immediate written notice to the City if, at any time during the term of this Agreement, the Contractor learns that the Contractor's disclosure was at any time erroneous or became erroneous by reason of changed circumstances.

D. A disclosure that any of the items in this requirement exist will not necessarily result in termination of this Agreement. However, the disclosure will be considered in the determination of the Contractor's responsibility and ability to perform under this Agreement. Failure of the Contractor to furnish a disclosure or provide additional information as requested will be grounds for immediate termination of this Agreement pursuant to the conditions set forth in Paragraph 7 of this Agreement.

E. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render, in good faith, the disclosure required by this document. The knowledge and information of a Contractor is not required to exceed that which is the normally possessed by a prudent person in the ordinary course of business dealings.

F. The disclosure requirement provided is a material representation of fact upon which reliance was placed when making an award and is a continuing material representation of the facts during the term of this Agreement. If during the performance of the contract, the Contractor is indicted for or otherwise criminally or civilly charged by any government entity (federal, state or local) with commission of any offenses named in this document the Contractor must provide immediate written notice to the City. If it is later determined that the Contractor knowingly rendered an erroneous disclosure, in addition to other remedies available to the Government, the City may terminate the involved contract for cause. Still further the City may suspend or debar the Contractor from eligibility for future solicitations until such time as the matter is resolved to the satisfaction of the City.

35. **Notification**

Either party may give written notice to the other party in accordance with the terms of this Paragraph. Any written notice required or permitted to be given hereunder shall be deemed to have been given on the date of delivery if delivered by personal service or hand delivery or three (3) business days after being mailed.

To the City:

Rich Brown, Director – Community Development
500 Market Street, 2nd Floor
Santa Fe, NM 87501
Mobile: 505. 955-6625

To the Contractor:

Hilario (Larry, Jr.) Chavez, Superintendent
610 Alta Vista,
Santa Fe, NM 87505
Santa Fe Public Schools
Office: 505. 467-2000

Either party may change its representative or address above by written notice to the other in accordance with the terms of this Paragraph. The carrier for mail delivery and notices shall be the agent of the sender.

To the Contractor:

Hilario (Larry, Jr.) Chavez, Superintendent
610 Alta Vista,
Santa Fe, NM 87505
Santa Fe Public Schools
Office: 505. 467-2000

35. **Succession**

This Agreement shall extend to and be binding upon the successors and assigns of the parties.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the date of the signature by the required approval authorities below.

APPROVED BY:

PETER MCWAIN, EXECUTIVE DIRECTOR
CURRICULUM & INSTRUCTION

10/25/2022
DATE

VANESSA ROMERO, DEPUTY SUPERINTENDENT
OF TEACHING & LEARNING

10/25/2022
DATE

JOSH GRANATA, GENERAL COUNSEL — DATE

ROBERT L. MARTINEZ II, CHIEF FINANCIAL OFFICER — DATE 10/31/2022

HILARIO "LARRY" CHAVEZ, SUPERINTENDENT OF SCHOOLS — DATE 10/31/22

CITY OF SANTA FE:

MAYOR ALAN WEBBER

DATE:

ATTEST:

KRISTINE BUSTOS MIHELCIC, CITY CLERK

CITY ATTORNEY'S OFFICE:

Marcos Martinez
Marcos Martinez (Nov 10, 2022 16:13 MST)

SENIOR ASSISTANT CITY ATTORNEY

APPROVED FOR FINANCES:

EMILY OSTER, FINANCE DIRECTOR

2400122/510340 ($158,333)
2402850/510340 ($639,267) AH
AH

Org.Name/Org.Number

RECOVERY FUNDS SUBRECIPIENT
CONTRACT BETWEEN CITY OF SANTA FE AND THE SANTA FE PUBLIC SCHOOLS FOR WORK-BASED LEARNING PROGRAM
EXHIBIT A: SCOPE OF WORK

COSF: OED Work-based Learning ARPA Funding Project	Scope of Work	2022-23	2023-24	Budget Breakdown/year
Bucket 1: SPFS Juniors/Seniors - Paid Internships	Screen, Select, & Place 60 SFPS Junior and Senior high school student interns in Santa Fe, NM high-value industries	$127,400	$218,400	60 Students (*) $14/hour @ 260 hours (annual)
Bucket 2: 4 SFPS Mentors (Internship Teachers)	Internship Teacher Team at SFHS, CHS, ECO, DSA: Provide Employability Skills "Bootcamp" Training to intern cohort, including - Resume Building, Interview Skills, & Soft Skills. Weekly progress monitoring with interns during internship.	$18,667	$32,000	4 Mentors (*) .14 FTE Position Based on Teacher Level Rate of Pay (annual)
Bucket 3: 1 Work-Based Learning (WBL) Specialist	Professional Support Staff: Develop and implement - Student and Supervisor (Mentor) friendly online platforms; Internship Site Visits; other administrative duties as assigned	$58,333	$100,000	1 Professional Staff Salary + Benefits (annual)
	SUM	$204,400	$350,400	
SFPS: Partners				
Bucket 4: Business Outreach	Provide Business Connections & Warm Introductions: Engage, collaborate w/ WBL Coordinator, and pitch WBL program to 20+ business partners	$30,000	$0	1 Professional Staff Salary + Benefits (annual)
Bucket 5: Dropout Recovery Paid Internships	Recruit Students Ages 16-21 who have dropped out of school or referred by the SFPS District; Provide Group Internships through Earthcare	$78,400	$134,400	40 Students (*) $14/hour at 240 hours (annual)
	SUM	$108,400	$134,400	
	Grand Total	$312,800	$484,800	

RECOVERY FUNDS SUBRECIPIENT
CONTRACT BETWEEN CITY OF SANTA FE AND THE SANTA FE PUBLIC SCHOOLS FOR WORK-BASED LEARNING PROGRAM
EXHIBIT B – PERFORMANCE MEASUREMENTS

COSF: OED Work-based Learning ARPA Funding Project	Performance Measurements
Bucket 1: SPFS Juniors/Seniors - Paid Internships	80% internship success rate; e.g., 48 out 60 interns will complete internship.
Bucket 2: 4 SFPS Mentors (Internship Teachers)	95% mentorship success rate; e.g., all mentors will complete internship roles and responsibilities.
Bucket 3: 1 Work-Based Learning (WBL) Specialist	1st year: Social Media Platforms 100+ followers. Website Analytics: 100+ viewers/users. Newsletter: 100+ Subscribers.
SFPS: Partners	
Bucket 4: Business Outreach	Deliver no fewer than 20 new business partners.
Bucket 5: Dropout Recovery Paid Internships	60% internship/graduation success rate; e.g. 24 out of 40 interns will complete internship and graduate.

City of Santa Fe, New Mexico
memo

Date: **November 15, 2022**

To: **JoAnn Lovato, Acting Purchasing Officer**

From: Julie Sanchez, Youth and Family Services Division JJS

Subject: **Exemption Determination Request, 13-1-98 #A**

The Community Health and Safety Department respectfully request exempt determination to be approved by the City's Acting Purchasing Office, JoAnn Lovato, for the following scope of work (SOW):

1. **Scope of Work**

A. The Contractor shall perform the work as outlined in Exhibit A, attached hereto and incorporated herein by reference.

B. Performance measures as outlined in Exhibit 8.

C. The attached performance measurements are preliminary and are an estimated goal. The Agreement Administrator and Contractor will re-evaluate and agree upon performance measurements, on a quarterly basis to align realistic measures for the following year.

D. The Contractor will recruit and offer all Work-Based Learning internship opportunities to students that are interested in the internship program as categorized in the demographic distribution below:

a. Students with one or more disabilities
b. Low-Income Students
c. English Learners
d. Migratory Students
e. Students Experiencing Homelessness
f. American Indian/Alaska Native

g. Black or African American
h. Hispanic/Latino
i. White
J. Two or more races or mixed races

E. The City agrees to provide summer and/or school l year internships to SFPS students, based on current capacity needs.

i. The Partner agrees to comply with the Family Educational Rights and Privacy Act ("FERPA") 20 U.S.C. § 1232g; 34 CFR Part 99.

ii. CRIMINAL BACKGROUND CHECK.

For any individual providing services pursuant to the City's explicit or implicit direction or permission, the City shall make one of the following warranties, in compliance with Megan's law and §22-lOA-5 NMSA 1978 of the School Personnel Act.

1. By this signature _____, SHALL WARRANT that such individuals will not have unsupervised access to students, OR
2. By this signature _____, SHALL WARRANT that the individual who will have unsupervised access to students has no felony convictions and is not a registered sex offender, as verified by the Partner's:
   a. Performance of an internet search on the individual; and
   b. Completion of a federally recognized fingerprint and background check on the individual no more than five (5) years prior to, and no later than the first business day of, commencement of services under this Agreement.

H. The Santa Fe Public Schools understands that this contract represents a subaward of SLFRF funds, agrees to maintain records to satisfy all compliance requirements for use of SLFRF, and agrees to all reporting requirements for expenditures of SLFRF funds.

City of Santa Fe follows the New Mexico State Procurement Code (NMPC) & City of Santa Fe Procurement Manual (COSPM).

NMPC, NMSA, 1978 13-1-98 & COSPM, Item VI. Exemptions from the Procurement Code.

13-1-98-A NMPC/ #1 COSPM
Provide language of exemption cited

1. *Procurement of items of tangible personal property of services by the City from a state agency, a local public body or external procurement until except as otherwise provided in NMSA 1978, §13-1-135 to §13-1-137.*

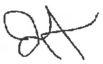
Amount: $ 797,600.00.

Term: 11/2022 through 06/30/2024

Approved Exemption

JoAnn Lovato
JoAnn Lovato (Nov 15, 2022 16:05 MST)

JoAnn Lovato, Acting Purchasing Office

Signature: 

Email: jjsanchez@ci.santa-fe.nm.us

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 8/8/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Poms & Associates Insurance Brokers CA License #0814733 5700 Canoga Avenue Woodland Hills, CA 91367	CONTACT NAME: Risk Services PHONE (A/C, No, Ext): (800) 578-8802 FAX (A/C, No): (818)449-9449 E-MAIL ADDRESS: rservices@pomsassoc.com
INSURED New Mexico Public Schools Insurance Authority Member: Santa Fe Public Schools 4110 Old Taos Highway Santa Fe, NM 87501	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : New Mexico Public Schools Insurance Authority — N/A INSURER B : Safety National INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	COMMERCIAL GENERAL LIABILITY CLAIMS-MADE [ ] OCCUR [X] [X] Owners Contractors Protective Liability GEN'L AGGREGATE LIMIT APPLIES PER: [X] POLICY [ ] PRO-JECT [ ] LOC			MOC NO L0025	07/01/2022	07/01/2023	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG Maximum Liability	$ Tort Limit $ Tort Limit $ Tort Limit $ Tort Limit $ Tort Limit $ Tort Limit $ 1,050,000
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) Maximum Liability	
	UMBRELLA LIAB [ ] OCCUR EXCESS LIAB [ ] CLAIMS-MADE DED RETENTION $						EACH OCCURRENCE AGGREGATE	
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] N/A (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	
							Each Occurrence Maximum Liability	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

See attached New Mexico Tort Claims Act Section 41-4-19: Maximum Liability Summary. Cert Holder is additional insured if required by written contract. General Liability Retention=$750K.

CERTIFICATE HOLDER

City of Santa Fe, Youth & Family Services
PO Box 909
Santa Fe, NM 87504

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

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AGENCY CUSTOMER ID: _____

LOC #: _____

ADDITIONAL REMARKS SCHEDULE

AGENCY		NAMED INSURED
Poms & Associates Insurance Brokers		New Mexico Public Schools Insurance Authority
POLICY NUMBER		
CARRIER	NAIC CODE	EFFECTIVE DATE:

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,

FORM NUMBER: _____ FORM TITLE: : Notes

Summary of New Mexico Tort Claims Act Section 41-4-19:
Maximum Liability Governmental entities and agencies, including public schools, public charter schools and community colleges and universities are granted immunity from liability.
Commercial General Liability Products and Completed Operations Professional Liability Contractual Liability Imposed by New Mexico Tort Claims Act [NMSA 1975 §41-4-1 through 41-4-29]
$400,000 Bodily Injury Per Person
$200,000 Property Damage Per Property Address
$300,000 Medical
$750,000 Per Occurrence
$1,050,000 Combined Limit/Maximum Liability

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SFPS
Santa Fe Public Schools
Striving for Excellence

Santa Fe Public Schools

Signature Request and Routing Form

Date Requested for Return to Originator:

Date Initiated: 10/24/2022 **Due Date To Outside Entity: 10/28/2022**

Originating Department: Curriculum & Instruction

Type of Document: Grant MOU Professional Service Agreement X Other: Intergovernmental Agreement

Other: Gift/Donation - Board Approval

Name of Grant/Funding Agency/Organization/Contractor: City of Santa Fe: Office of Economic Development

Summary: Work-Based Learning Partnership: Paid Internships, Professional Staff, PSA Partnerships - Dropout Recovery, Paid Internships, Business Recruitment

Funding Source (include source code) : N/A

Cost Implication(s): None

Staff Implications(s): Jose Villarreal

Submitted by: Curriculum & Instruction

Place an "X" or "N/A" in the box to indicate what action is needed.

Signatures	Review	Additional Action Required	Notes (indicate specific page(s) needing signature
Peter McWain, Executive Director for C&I 10/25/2022	X		
Joshua Granata, Legal Counsel	X		
Vanessa Romero, Deputy Superintendent for Teaching & Learning 10/25/2022	X		
Robert L. Martinez II, Chief Financial Officer 10/31/2022	X		
Other Required Signature(s)			
Hilario "Larry" Chavez, Superintendent of Schools	X		*Sign pg. 8*
Board Representative			

SANTA FE PUBLIC SCHOOLS
ROUTING SLIP

Initiated by: Peter McWain Phone: 505-467-2569 Date: 10/28/22 Rec'd. by: Marie Gutierrez

SFPS Contract Number: 22-23-820-191-1 (Fiscal Year-Dept Code-Agreement #-Type of Contract) Dept./School Name: Curriculum & Instruction

Contractor Name: City of Santa Fe $312,800.00 (incoming Money)

WHEN YOU RECEIVE A PSA, SERVICES CONTRACT, MOU, OR ADDENDUM PLEASE ROUTE ACCORDINGLY

(Person reviewing document should hand-deliver document to next person on the routing slip for review).

Please Keep the Routing Sheet Attached to Original Contract.

PERSON RECEIVING DOCUMENT		INITIALS	DATE
1. **TO: Business Services** (An Agreement number will be assigned, a blue routing slip will be attached, and forwarded to the appropriate Accountant). _X_ Complete Contract: Date, Scope of Services & Compensation. _X_ Comply with Megan's Law. _X_ Comply with Disclosure of Contributions _X_ Contractor's Signature		MG	10/28/22
2. **TO: Appropriate Accountant** in Business Services for approval & initials for funding source, line item & budget. Accountant will give to CFO to sign off for Business Services.(Business Services will forward to appropriate Executive Team Member).			
3. **TO:** • Chief Financial Officer, **OR** • Deputy Superintendent, **OR** • Associate Superintendent, **OR** • Chief Operations Officer, **OR** • HR Director	* **AND** Technology Director: if technology is involved. (Technology includes: phones, surveillance equipment computer systems, software, etc.)		
		VR see signature page RM see signature page	10/25/22
4. **TO: Superintendent Office** (when more than $60,000) or Designee for review.		HC see signature page HB	10/31/22
5. **TO: Board of Education for approval** (when over $60,000). **For Approval at the** _____ (Date) **Board Meeting** ☐ **Approved** ☐ **Not Approved**		NA	
6. **TO:** Appropriate Executive Team Member's office will route back to Business Services/Contracts to scan and e-mail to Initiator			
7a. **TO: Initiator** to attach contract with a requisition in the iVisions System for the purchase order processing. ***Please reference the contract # on all requisitions.***			
7b. **TO: Initiator:** (If requisition is *not* required). The Initiator obtains the Contractor's signature & returns the signed original to: Business Services Office; Copies to: Contractor & Initiator. **OR** If PTO/PTC Contract: The Initiator obtains the PTO/PTC President/Vice President's signature & returns the signed original to: Business Services Office; Copies to: PTO/PTC, Initiator and Human Resources.			
8. Original contract and Routing Slip will remain in Business Services/Contract Office. Initiator may obtain copy of contract through iVisions to copy for Contractor			
COMMENTS:			

City of Santa Fe New Mexico
Memorandum

Date: November 3, 2022

To: Governing Body

Via: Erin K McSherry, City Attorney EM

From: Jesse Guillen, Legislative Liaison

RE: Locally Grown Food

ITEM AND ISSUE:

Consideration of a Resolution in support of an appropriation from the New Mexico State Legislature for the New Mexico-Grown Fresh Fruits and Vegetables for School and Senior Meals Programs that provides locally grown produce for students and seniors.

BACKGROUND AND SUMMARY:

The purchase of New Mexico grown fruits and vegetables will enhance the diet of school children and seniors and help school and senior meal programs comply with federal rules that require fruits and vegetables on meal plates. The support from the New Mexico State Legislature has proven invaluable for many of the City of Santa Fe seniors and children.

ACTION REQUESTED:

Adopt the Resolution as presented.

ATTACHMENTS:

Resolution
Fiscal Impact Report

CITY OF SANTA FE, NEW MEXICO

RESOLUTION NO. 2022-___

INTRODUCED BY:

Councilor Jamie Cassutt

Councilor Renee Villarreal

A RESOLUTION

SUPPORTING THE APPROPRIATION OF FUNDS BY THE NEW MEXICO LEGISLATURE FOR NEW MEXICO-GROWN FRESH FRUITS AND VEGETABLES FOR SCHOOL AND SENIOR MEALS PROGRAMS AND RELATED EDUCATION PROGRAMS FOR SCHOOLS AND FARMERS.

WHEREAS, New Mexico has a vibrant food and farming culture that is significant to its rural economies that is the fourth largest economic sector and provides employment opportunities on farms and in the direct, wholesale, and retail markets, as well as in food processing, distribution, and value-added businesses, all while adding to the health and well-being of New Mexicans; and

WHEREAS, according to the United States Department of Agriculture Census of Agriculture, 2017 ("Census"), 1,538 New Mexico farmers sold $98 million dollars' worth of vegetables and melons and $210 million dollars' worth of fruits, nuts, and berries in 2017; and

WHEREAS, the New Mexico Legislature passed, and Governor signed the Food Initiative, a $24.7 million program, as part of the state budget, to increase investment in New Mexico's food, hunger, and agriculture initiatives; and

WHEREAS, a March 31, 2021, study released by Feeding America, said that in 2019 10.6% of Santa Fe County residents experienced food insecurity[1]; and

WHEREAS, the New Mexico Human Services Department reports that in 2021 17 % of Santa Fe's children under age 18 repeatedly experienced food insecurity; and

WHEREAS, according to the New Mexico Public Education Department ("PED"), approximately 333,300 students are enrolled in New Mexico schools and can participate in the school meal programs operated by various schools throughout the state, and more than 241,400 of these students -- 72 percent -- are eligible for free or reduced-price school meals; and

WHEREAS, the Food Service Director for the Santa Fe Public Schools stated in 2021 that seventy percent of students in Santa Fe County and the City of Santa Fe participated in the school meal program; and

WHEREAS, in 2022, the New Mexico School Nutrition Association found that, due to inflation, local school meal programs have seen costs for food purchases increase by up to 25 percent; and

WHEREAS, federal funding supports school meals programs through the National School Lunch Program that is funded through the Child Nutrition Reauthorization; and

WHEREAS, information from PED shows that the National School Lunch Program provides public schools with a reimbursement of $4.83 for free lunches, $4.43 for reduced-priced lunches; and $1.27 for fully paid lunches; and

WHEREAS, the National School Lunch Program provides public schools with a reimbursement of $2.82 for free breakfasts, $2.52 for reduced-price breakfasts, and $0.65 for fully paid breakfasts; and

WHEREAS, the Healthy School Meals for All Bill (Universal School Meals Program Act

[1] https://feedingamericaaction.org/resources/state-by-state-resource-the-impact-of-coronavirus-on-food-insecurity/

of 2021) made school breakfasts and lunches free for all children; and

WHEREAS, the State's purchase of New Mexico grown fruits and vegetables for school lunches and senior meals programs in New Mexico and will enhance the diet of school children and seniors and help school and senior meal programs comply with federal rules that require fruits and vegetables on meal plates; and

WHEREAS, there is an agricultural sector of fruit and vegetable farmers in New Mexico that can respond to these new food markets for local produce in the school and senior meal programs; and

WHEREAS, food and agriculture education programs and experiential learning are key to increasing student access to and relationships with fresh and local produce, as well as to introducing students to possible career paths; and

WHEREAS, increased funding from the State Legislature enables senior, early childhood education and school meal programs and local school districts to purchase New Mexico-grown produce, serve more fresh fruits and vegetables to Santa Fe's children and seniors for their health and well-being, provide related educational materials and experiential learning opportunities, and support economic development and opportunities for local farmers; and

WHERES, seventy-five percent of the funding in the federal Farm Bill is the Supplemental Nutrition Assistance Program (SNAP), which provides food security to nearly 540,000 New Mexicans; and

WHEREAS, the GusNIP (Nutrition Incentive Program) Double Up Food Buck Program provides important access to locally grown and raised foods in New Mexico; and

WHEREAS, the Santa Fe Farmers' Market Institute reported over $375,000 worth of GusNIP Double Up Food Buck Program and SNAP sales in 2021 that both provided a nutrition benefit to those who are food insecure and an economic benefit to the region's farmers and ranchers; and

WHEREAS, the federal Farm Bill Fresh Rx Program provides patients who are at-risk for long-term diet related health outcomes due to unhealthy diets and/or lack of access to nutritious foods fresh fruit and vegetable prescriptions to use at local farmers' markets; and

WHEREAS, the Santa Fe Farmers' Market Institute reported an increase of nearly 400 percent in the Fresh Rx program utilization year to date in 2022; and

WHEREAS, federal Farm Bill programs are designed to provide technical assistance and conservation programs to assist farmers and ranchers in land stewardship and building their businesses.

NOW, THEREFORE, BE IT RESOLVED that the Governing Body supports the Legislature's continued funding to expand the New Mexico Food Initiative and programs such as the New Mexico-grown fresh fruits and vegetables for school and senior meals programs, related education programs, the New Mexico Food Security Grant Program, and programs that expand opportunities for farmers and ranchers.

BE IT FURTHER RESOLVED that the Governing Body supports the federal Child Nutrition Reauthorization programs to benefit New Mexico such as the Healthy School Meals for All Bill, which will provide free breakfasts and lunches for all children and increased funding for programs such as Kids Eat Local Act, the School Food Modernization Act, the Women, Infants, and Children Program (WIC), and WIC Farmers' Market Nutrition Programs.

BE IT FURTHER RESOLVED that the Governing Body supports federal Farm Bill programs that strengthen food assistance programs, ensure sufficient resources and access to nutritious food for all people, and increase resources for New Mexico farmers and ranchers.

BE IT FURTHER RESOLVED that the Governing Body supports the New Mexico Food & Agriculture Policy Council's federal Child Nutrition Reauthorization and Farm Bill recommendations.

PASSED, APPROVED, and ADOPTED the __ day of _____, 2022.

_____

ALAN WEBBER, MAYOR

ATTEST:

_____

KRISTINE MIHELCIC, CITY CLERK

APPROVED AS TO FORM:

ERIN K. McSHERRY, CITY ATTORNEY

Legislation/2022/Resolutions/Locally Grown Food

FIR No. 10472

FISCAL IMPACT REPORT

General Information:

(Check) Bill: _____ Resolution: X

Short Title(s): Locally Grown Food

Sponsor(s): Councilors Cassutt and Villarreal

Reviewing Department(s): City Attorney's Office

Staff Completing FIR: Jesse Guillen Date: 10/13/22 Phone: 955-6518

Reviewed by City Attorney: _____ Date: Nov 3, 2022

Reviewed by Finance Director: Emily K. Oster Emily K. Oster (Nov 3, 2022 16:38 MDT) Date: Nov 3, 2022

Summary:
This Resolution supports the New Mexico State Legislature's appropriations for the New Mexico-Grown Fruits and Vegetables for School Meals Program and other related programs.

Departments Affected:
None.

Consequences of Not Enacting Legislation:
If this legislation is not adopted, the Governing Body would not state its support for this program that benefits over 16,000 students in Santa Fe County.

Conflict, Duplication, Companionship, or Relationship to Other Legislation:
The Governing Body has adopted Resolutions in the past that support this appropriation request from the New Mexico State Legislature.

Performance and Administrative Implications:
None associated with this Resolution.

Fiscal Implications:
None identified.

Fiscal Impact

X Check here if no fiscal impact

Expenditures

Expenditure Type	FYE __	FYE __	FYE __	Require BAR (Y/N)	Recurring (R) or Non-recurring (NR)	Fund	3-Year Total Cost
Personnel and Benefits*	$	$	$				
Capital Outlay	$	$	$				
Contractual/ Professional Services	$	$	$				
Operating	$	$	$				$
Total:	$	$	$				$

* This includes all staff time associated with executing the job functions of the proposed legislation.

Expenditure Narrative:

None Identified.

Revenue

Revenue Type	FYE __	FYE __	FYE __	Recurring (R) or Non-recurring (NR)	Fund
General Fund	$	$	$		
Special Revenue	$	$	$		
CIP	$	$	$		
Enterprise	$	$	$		
Internal Service	$	$	$		
Trust and Agency	$	$	$		
Federal	$	$	$		
Other	$	$	$		
Total	$	$	$		

Revenue Narrative:

None Identified.

NEW MEXICO
Food & Agriculture
POLICY COUNCIL

Farm Bill Priorities
August 2022

The New Mexico Food & Agriculture Policy Council is focused on the 2023 Farm Bill and Child Nutrition Reauthorization. As we consider a wide range of Farm Bill priorities, we appreciate the opportunity to share and highlight how programs are working in New Mexico and some recommendations to consider for the upcoming Farm Bill that may provide more equitable access to programs by individuals, families, communities, farmers, ranchers, support organizations, and agencies.

We want to thank New Mexico's Congressional Delegation and staff for the opportunity to meet in person with our group of farmers and support organizations to share our Farm Bill and Child Nutrition program highlights from our specific experiences and to provide a few recommendations.

Over Arching Recommendations:

1) Provide equitable access to Black, Indigenous and People of Color (BIPOC) who may have been historically discriminated against or marginalized, to all USDA programs and resources;
2) Provide a sliding scale approach to USDA programs access such as decreasing required matches depending on applicants' budgets and provide "turnkey" grants (no match required) for program requests less than $50,000 for one-year requests;
3) Urge set asides for specific programs especially in Tribal and underserved communities;
4) Make funding available within the year of an approved loan or grant contract; and,
5) Increase USDA staff and technical assistance to meet the needs of all people and communities;
6) Strengthen protocols used in the determination of minority preference.

Teresa: start us off with hunger and access in NM

II Conservation Programs (Lawrence and Roger – please add your suggestions here)

- The importance of increased funding and targeted **EQIP in NM** that meet the needs of farmers, ranchers, and acequia participants
- Requesting options to make the **Conservation Reserve Program** (CRP) more flexible
- **Conservation Technical Assistance** - **Lawrence**

- **Natural Resource Conservation Service Micro Loan Program - Jaime**
- **Grazing Lands Conservation Program - Lawrence**
- **Agriculture Resilience Act:**
    - Supports soil health programs, on-farm renewable energy, food loss and waste programs, pasture-based livestock, and farmer viability through **LAMP.**
- **Lawrence. Anthony**

Title IV Nutrition

- **Senior Farmers' Market Nutrition Program (FMNP)**
    - New Mexico's seniors and farmers have benefited from the Senior FMNP for close to two decades. Federal fund for the Senior and WIC FMNP leverage important federal funding. In 2020, 60,000 low-income residents purchased NM produce with federal and state dollars totaling $408,351 (ref: NM Farmers' Marketing Association)
    - **Recommendations:**
        - Make the program accessible to all state to apply based on low-income and food insecure senior populations.
        - Increase funding to $50 million annually (currently at $25 million)
        - Additional Admin Funds for the use of Full Time employees, as the vision for the NM Senior Program is to expand our program and have 1-2 staff in each region to assist Markets, farmers and participant with a large Outreach to all Senior Programs within their Region.
        - Advertising Funds- Facebook has been a great help, however we would love to provide our Markets, Farmers, Senior Program, Community Programs, advertisement information of our program.
        - Additional Funding for Seniors- to issue more than the $50.00 for the Season. NM WIC & Senior Program issues once per year starting In July and we have many food insecure Seniors that have been asking if there is any possibility of receiving funds on a monthly basis as it truly helps them fill their fridges and canning storages
        -

- **GusNIP – Nutrition Incentive Program - Kierstan**

The Gus Schumacher Nutrition Incentive Program (GusNIP) provides grants on a competitive basis to projects that help low-income consumers access and purchase fresh fruits and vegetables through "cash" incentives that increase their purchasing power at locations like farmers
markets. GusNIP consists of subprograms for both traditional "SNAP incentives" projects and "Produce Prescription" projects.
Recommended reforms:

- Increase funding for SNAP incentives and Produce Prescription projects to $200 million/year or 1% of total SNAP spending

- Reduce match requirements for SNAP incentives and Produce Prescription grants to 10%
- More targeted Technical assistance and outreach to BIPOC / socially disadvantaged communities and organizations.
- Clarify program design, that all 3 redemption models (produce for produce, SNAP for produce, produce for SNAP) should be allowable
- **Pr**ovide dedicated funding for existing, statewide programs
- Allow states to embed incentive directly on state EBT/SNAP card
    - Led by Senator Stabenow

- **Geographic Preference for School Meals – *Kids Eat Local bill language***
    - Clarifies and simplifies to improve on past efforts to increase local purchasing
    - Sponsored by: Senator Brown & Congresswoman Pingree
    - **USDA Farm to School Grant Program**

- **USDA Farm to School Grant Program (In the Child Nutrition Reauthorization) - Marie**
    - Farm to School Grant Program, administered by the Food and Nutrition Service, awards competitive grants of up to $500,000 to schools, school districts, state and local governments, Native American tribal organizations, non-profits, and agricultural producers. This funding supports a wide range of activities that support the healthy development of children in ECE settings and students across the nation, including activities that increase diet quality and improve long-term nutrition skills. Farm to school activities help to develop partnerships, establish supply chains, create new menu items, provide nutrition education, establish school gardens, encourage increased consumption of fruits and vegetables, and organize field trips to agricultural operations. Farm to school activities have also been found to increase student and teacher meal participation.

Recommendations:

- Increase funding
- Maintain turnkey granting of $50,000 or less
- Decrease 1 for 1 match to a sliding scale based on applicants' annual budget

- **Produce Procurement Reform - *NEW – Pam & Kendal***
    - Learning from the pandemic, there is a opportunity to create a new fresh produce emergency distribution program prioritizing local, small & midsized, BIPOC producers based on the successful contracts from the **Local Food Purchase Assistance Program.** New Mexico just receive **a Local Food Procurement Agreement Project** (more than $2 million over two years), an example of what a federal program like this can do to benefit New Mexico's food insecure individuals and communities New Mexico provide market opportunities

for farmers, a partnership between the NM Department of Agriculture, NM Farmers' Marketing Association and the NM Association of Food Banks.

- **Healthy Food Financing Initiative**
    - As part of the NM Food Farm and Hunger Initiative, the State has appropriated funds that can match federal dollars to support healthy food retail and food hub operations to strengthen and expand New Mexico local food systems and farming economy.

- **Community Food Project Grant Program** has been a long-standing program that has helped many NM communities get food system initiatives off the ground including food hubs and rural grocery initiatives, increasing food access initiative in rural and underserved urban areas, farm to school programs.

- **Food Distribution Program on Indian Reservations**
    - Recommendation: provide local preference option

VI Rural Development

- **Value Added Producer Grants** (VAPG)
    - Increase funding
    - Reduce match for producers earning less than $250,000, AGI to 25%
    - Create new lending and loan guarantee authority for producers to purchase equipment and construction of facilities for value added products
    - Allow for loans to non-rural projects if a primary purpose is to benefit rural communities/producers
    - Priority for projects benefitting underserved communities
    - Loan and guarantee appropriations authorization of $10 million/year
- **Rural Energy Assistance Program (REAP):** used by farmers and ranchers in NM.
- **Support set aside for conservation programs.**

- **Value – Added Infrastructure: marker bill ideas** (**follow the law** – program already exists. Higher transaction should be a grant to communities in need (low-income demographic) USDA Rural Development Guaranteed Loan Program)

Emergency Loans:
Will farmers and individuals be taxed for their emergency funds

X Horticulture

- **Local Agriculture Marketing Program (LAMP)**

- LAMP is an umbrella program that consists of the following separate subprograms: the Farmers Market and Local Food Promotion Program (FMPP and LFPP), the Value Added Producer Grant (VAPG) Program, and the Regional Food Systems Partnership (RFSP) Program.
- **Recommendations:**
    - Farmers' Market Nutrition Program (FMPP) - Kierstan
        - Increase funding
        - Create turnkey grants for common projects of less than $100K with no match requirement
        - Provide AMS authority to award priority points to ensure geographic diversity
        - Reduce match to 10% for organizations with annual budgets of less than $350K
        - Allow for a limited amount of grant funds to be used for equipment
    - **Local Food Promotion Program (LFPP) - Kierstan**
        - Increase funding
        - Create turnkey grants for common projects of less than $100K with no match requirement
        - Provide AMS authority to provide priority points to ensure geographic diversity
        - Reduce match to 10% for organizations with annual budgets of less than $350, 000
        - Allow for a limited amount of grant funds to be used for equipment
    - **Regional Food Systems Projects** (RFSP) - Pam
        - New Mexico is one of the first recipients of this new program at close to $1 million in grant funding over 4 years matched my state and private funds.
        - **Recommendations include:**
            - Increase funding
            - Ensure that regional food chain coordination is a recognized activity for all programs

Farm & Ranch Support Programs - Yani

- **Farming Opportunities Training and Outreach Program** (FOTO), established in Section 12301 of the 2018 Farm Bill. The FOTO program merged the authorities for the **Beginning Farmer and Ranchers Development Program** (BFRDP) and the **Outreach and Assistance for Socially Disadvantaged and Veteran Farmers and Ranchers** (also known as 2501). The $10 million funding request would meet increased needs for the effective combination of education and training models designed to support new farmers and historically underserved producers.

- **Prioritize programs that support veterans in farming and ranching:**
    - Continue to fund the military veteran's agricultural liaison position, and make sure the person holding that title has that role as their sole responsibility and support staff.
    - Continue to support the enhancing agricultural opportunities for military veterans (agvets) grant program.
    - Support the National Agrability Project

- Requesting support for the **Small and Very Small Processor Support Programs and FSIS Fees** for s**mall scale meat processing such as the** C4 Farms ranch near Tierra Amarilla.
- **USDA Meat & Poultry Inspection Readiness Grant:** Agriculture Secretary, Tom Vilsack, announced on Nov. 22, 2021 that the US Department of Agriculture (USDA) would invest $32 million in grants to 167 meat and poultry slaughter and processing facilities to support expanded capacity and efficiency. New Mexico awardees include C4 Enterprises Inc., award $198,000 near Tierra Amarilla and the MGS Enterprises Award Amount: $200,000 in the Four Corners Area.

- **Concern:**

- Strengthen protocols in determining minority determination and priority of programs

- Some land-owners who are well resourced may lease land to people who qualify for the resources but the land owner receives the resource.
- *Ask Casey Holland, Chispas Farm, how she was able to work with NRCS and the landowner she leases from.*
- **Look at National Young Farmers Coalition Farm Bill priorities**

XII Miscellaneous

- Urban Agriculture: numerous NM organizations and farms have applied to this new grant program.

Agriculture Labor: (Pam added)

We support agricultural labor standards including:

- Worker protection standards regarding wage rates, health, safety, and housing conditions to migrant, seasonal, minority and other farm laborers and for education of their children;
- A right to organize; and,
- A livable wage that includes all compensation (includes wages, housing…)

- *This helps to modify the Fair Labor Standards Act (of 1938) and the National Relations Act (of 1936)*

We support the creation of a program, similar to the Fair Food Program, assuring a voluntary, worker-driven collaborative process between farms and workers on farms to deliver certifiable, market rewarded, and market-enforced payment of products to benefit wages, profits, and livelihoods of workers and farmers.

We ask USDA to create incentives for participation in the program. Programs like these could allow workers to gain more market share towards wages, accountability of employers for fair standards and hearing grievances, and buy-in from food product end users to ensure that goods are not purchased at low-production cost and labor rates.

Forest Management

- We urge the implementation of the appropriate management of our forests.
- We support appropriate and full compensation for those harmed by loss of control of management practices, whether by mismanagement or "Act of God".

Child Nutrition Reauthorization – School Nutrition Programs: Marie

We support:

- Supporting Universal School Meals: Need higher reimbursement rates to cover all food, staff, and supplies
- Prioritizing culturally significant foods – grain alternatives such as starchy vegetable additional such as corn potatoes and tubers
- Allowing protein alternative's and increase funding
- Making it easier to have milk/dairy alternatives
- Increasing funding for equipment
- Prioritizing locally grown preferences
- Reducing administrative burdens

The **New Mexico Food & Agriculture Policy Council continues to research and refine its Farm Bill and Child Nutrition Reauthorization recommendations for 2022 – 2023**. We look forward to continued education and unifying our priorities to share with **NM's Delegation** and the New Mexico Delegation for your support and leadership.

Recommendations and suggestions as of August 22, 2022

Contact: Pam Roy, Farm to Table and the NM Food & Agriculture Policy Council, 505-660-8403, pam@farmtotablenm.org, https://nmfoodpolicy.org/

Farm Bill and Child Nutrition Reauthorization Priorities For New Mexico

In New Mexico, farming and ranching comprise our fourth largest economic sector. However, much of this economy is supported by community-based farms and ranches, many of which are owned by Indigenous peoples and other peoples who have historically been marginalized in the USDA model.

NEW MEXICO
Food & Agriculture
POLICY COUNCIL

As we struggle to find ways to support farmers and ranchers, and feed our communities, we realize that supporting equity in all policies is central to this work. We appreciate the opportunity to share our recommendations for how the Farm Bill and Child Nutrition Reauthorization can better reflect these needs.

Ensure Equity in All Policies

End Hunger In Our Communities

Increase Access to Farm Programs

Meet the Climate Crisis Head On

Ensure Safety and Dignity for Workers

Protect Farmers and Consumers

HEALTHY FOOD, HEALTHY ECONOMY, HEALTHY FUTURE

The New Mexico Food & Agriculture Policy Council is a statewide body representing farmers and ranchers, food service providers, hunger relief organizations and others who are invested in creating effective and integrated food systems. Working at the local, state and federal levels, we look for solutions to complex problems which allow communities to work together to provide nutritious, local and culturally-appropriate foods and to support our food and farming economies. Equity is at the heart of our approach to this work.

Ensure Equity in All Policies

The 2023 Farm Bill must confront the hard reality of past discrimination in communities that have historically been marginalized. We advocate for **ensuring equity in all policies** as a way to offset this marginalization. Farmers in communities of color, Tribal Nations, and immigrants add immeasurable knowledge and value to our food and farm systems, and are essential to their economic and environmental viability. Equity and justice must be at the center of every facet of the next Farm Bill if we hope to repair historical and ongoing discrimination against these communities and eliminate inequities throughout the food system.

What we can do:

1. Provide **equitable access** to Black, Indigenous and People of Color (BIPOC) who may have been historically discriminated against or marginalized, to all USDA programs and resources.
2. Provide **a sliding scale approach** to USDA programs such as decreasing required matches depending on applicants' budgets and provide "turnkey" grants (no match required) for program requests less than $50,000 for one-year requests.
3. Urge **set asides for specific programs** especially in Tribal and underserved communities.
4. Make **funding available within the year** of an approved loan or grant contract.
5. **Increase USDA staff and technical assistance** to meet the needs of all people and communities.
6. Strengthen protocols used in the **determination of minority preferences.**

End Hunger In Our Communities

In New Mexico **one in four families and individuals do not know where their next meal may come from.** To create greater food security, the Farm Bill must protect and strengthen food assistance programs to ensure sufficient resources and access to nutritious food for all people who struggle against hunger and food insecurity, particularly among elder populations. This measure will increase resiliance and will give students a greater chance to succeed.

The Farm Bill must **improve nutrition security** through consistent and equitable access to healthy, safe, affordable foods essential to optimal health and well-being for all.

What we can do:

1. Double the **Senior Farmers' Market Nutrition Program** and make it equitable for all states to apply based on low-income senior eligibility.
2. Increase the **GusNIP "Double Up Food Bucks" Program**, one of the best ways to address food security and provide economic opportunities for farmers. New Mexico has one of the most effective programs in the country.
3. Double funding for the **Healthy Food Financing Initiative** and prioritize underserved, rural and Tribal communities.
4. Double funding for the **Community Food Project Grant Program.**

For the Child Nutrition Reauthorization legislation:

School Nutrition Programs can be a lifeline to food security and nutritious meals.

What we can do:

1. Support **Universal School Meals.** We need higher reimbursement rates to cover all food, staff, and supplies while reducing administrative burdens.
2. **Prioritize culturally significant foods,** for example, alternatives to grains, such as starchy vegetables, corn, potatoes and tubers.
3. Allow **protein alternatives,** with increased funding.
4. Make it easier to have **milk/dairy alternatives.**
5. Increase **funding for equipment.**
6. Prioritize **locally grown** preferences.
7. Fund **nutrition and garden education** in the classroom and on the school grounds.

Increase Access to Farm Programs

What we can do:

1. Increase funding for the **Local Agriculture Marketing Program** including the Farmers' Market Promotion Program, Local Food Promotion Program, Value Added Producer Grants and Regional Food Systems Program.
2. Increase funding for **Socially Disadvantaged Farmers, Ranchers, and Veterans Program.**
3. Increase funding for **Farming Opportunities and Technical Outreach.**

Meet the Climate Crisis Head On

The Farm Bill needs to **support solutions to climate change** by investing in research, technical assistance, and financial incentives to enable farmers and ranchers to implement farming and practices that give them the ability to better steward the land, grow food for their communities, and make a living. The goal is to reward farmers and ranchers who implement healthy soil and conservation practices, while also enabling others to make these shifts, and discouraging farming practices that are harmful to the environment and public health.

What we can do:

1. **Double funding for conservation program** such as EQIP, Grasslands Conservation Program, Conservation Stewardship Program (CSP), and the Rural Energy Assistance Program (REAP).
2. **Minimize barriers** to these programs while providing more technical assistance.

Ensure Safety and Dignity for Food and Farm Workers

The pandemic revealed the vulnerability of the 20 million food and farm workers who are declared essential to feeding our nation. The Farm Bill must invest substantially in the people who plant, harvest, process, transport, sell, and serve our food, ensuring safety and a living wage, along with access to health care, clean housing, and the right to organize, while providing safe working conditions. New avenues are needed to support the aspirations of farmworkers and people who wish to become farmers, and access to citizenship for workers which does not tie them to exploitative labor practices and systems.

Protect Farmers and Consumers

The Farm Bill can and must build on our efforts to **promote competition** in the food and agriculture sectors. Anti-competitive practices harm small-scale farmers, workers, and consumers, and result in hollowing out rural communities and damaging our environment The Farm Bill should commit to an anti-competitive food and agriculture marketplace, while increasing long term investments in local and regional food processing and distribution. In this way, the Farm Bill can level the playing field for farmers and offer more and better choices to consumers.

The New Mexico Food & Agriculture Policy Council supports these priorities through our mission and values.

The mission of the New Mexico Food & Agriculture Policy Council is to advocate for food systems that strengthen the food and farm economies in New Mexico, and encourage and advance keeping food grown, raised, and processed in New Mexico, through support, education, and policy. Through our work we strive to enhance the health and wellness of people and communities, and to sustain natural resources.

A just, equitable, and sustainable food system is one that provides physical, economic and community health; regenerates, protects, and respects natural resources and animals; and ensures that all people live with dignity and freedom from oppression and exploitation.

Contact: Pam Roy, Farm to Table and the NM Food & Agriculture Policy Council, 505-660-8403
pam@farmtotablenm.org, https://nmfoodpolicy.org/

Signature:

Email: jbguillen@ci.santa-fe.nm.us

NEW MEXICO
Food & Agriculture
POLICY COUNCIL

Federal Child Nutrition Reauthorization Policies

What is CNR? The Child Nutrition Act Reauthorization ("CNR") authorizes federal school meal and child nutrition programs including the National School Lunch Program, the School Breakfast Program, and the Child and Adult Care Food Program, among others. The package of bills that make up CNR is meant to be reauthorized every five years, but the last CNR to pass was the Healthy, Hunger-Free Kids Act of 2010. That makes this upcoming CNR a **once-in-a-decade** opportunity to strengthen the programs that feed our nation's kids.

We believe that building the next CNR on **these four shared community values** will move us closer to a just, equitable food system that promotes the health of all school children and benefits producers, workers, educators, and their communities:

- **Economic justice:** Farm to School and ECE isn't just about food miles, it's about the livelihoods of the people who grew, harvested, processed, and prepared this food. We have the chance to build relationships between producers, workers, and consumers in ways that enrich communities and address economic racial injustices.

- **Environmental justice:** Education and the purchasing power of meal programs can shift our food system away from practices that contribute to climate change and pollute communities of color, and towards a more equitable, sustainable use of our soil and water.

- **Health impact:** Farm to school and ECE activities go beyond getting kids the calories they need, but also give them the tools for childhood nourishment and lifelong health. In addition to key nutrients provided by school meals, kids should be empowered with the knowledge and skills to build healthy habits later in life and increase their sovereignty in our food system. School nutrition professionals should receive the equipment, training, and operational support to increase whole-ingredient, scratch cooking of healthier and tasty meals.

- **Prioritizing racial equity:** Progress towards a just food system requires us to address the historic and ongoing structural racism embedded in our food system and to actively promote food sovereignty and racial equity in farm to school and ECE activities.

In order for these values to be realized, it is important that the most impacted stakeholders in our communities have a core role in the development and implementation of the next CNR.

Priorities:

- Recognize the right of every child to nourishing meals by supporting the **Healthy School Meals for All** (**Universal School Meals Program Act of 2021)** to make school breakfasts and lunches free for all children. **Learn more here.**
- Funding that will adequately fund the program and ensure equitable access to the successful USDA Farm to School Grant Program with the **Farm to School Act of 2021.**

Increase immediate opportunities for local- and values-based procurement by supporting:

- The **Kids Eat Local Act,** which would make it easier for schools to source local food for school meals. **Learn more here.**
- The **Local School Foods Expansion Act** which gives schools in 14 states more flexibility to purchase more fresh, local, unprocessed or minimally processed fruit and vegetables for school meals through expanding the successful Unprocessed Fruit and Vegetable Pilot Program.
- The **Small Farm to School Act**, which would create a federal pilot of local procurement incentives that give school meal programs more resources to shift to local producers.

Expand scratch cooking training and infrastructure by supporting:

- The **Scratch Cooked Meals for Students Act**, which would provide grant funding for culinary training and technical assistance, kitchen equipment, and infrastructure, prioritizing grants to school districts with a high percentage of students receiving free and reduced-price lunch and districts with labor agreements. **Learn more here.**
- The **School Food Modernization Act**, which would provide the funding needed for schools to upgrade their kitchen equipment. **Learn more here.**

Support our littlest eaters and their early care and education (ECE) providers with improvements to the Child and Adult Care Food Program, including:

- The **Early Childhood Nutrition Improvement Act**, which would streamline administrative burdens for providers, making it easier for them to participate in CACFP. **Learn more here.**

- The **Access to Healthy Food for Young Children Act,** which would increase access to CACFP for kids in day care homes and provide funding for an additional meal or snack on long days. **Learn more here**.

The **NM Food & Agriculture Policy Council** and **NM School Nutrition Association** appreciate your consideration of our request. The following New Mexico based organizations have endorsed the **Universal School Meal Program Act** request.*

Diné Food Sovereignty Alliance
Our Lady of Guadalupe
UNM Community Engagement Center
CPLC NM & HELP NM
New Mexico Center on Law and Poverty
New Mexico Coalition of Educational Leaders
Agri-Cultura Network / La Cosecha CSA
Santo Nino Carson Food Bank
Food Bank of Eastern New Mexico
San Martin de Porres Soup Kitchen
Economic Council Helping Others (ECHO), Inc.
Farmington Municipal Schools
Hobbs Municipal Schools
Raices del Saber Xinachtli Community School
Victory Life Church
The Food Depot
El Camino Real Academy After School Program
Boys & Girls Clubs of Santa Fe
Cooking with Kids, Inc.
Farm to Table
Los Amigos del Parque
Shiprock Traditional Farmers Cooperative
Rio Grande ATP
Shared Table Food Pantry
Truchas Services Center, Inc.
Gonzales Community School
Bright Beginnings CDC
Eastern Plains CAA, CACFP
New Mexico Association of Food Banks
New Mexico PTA

*Ref: Center for Science in the Public Interest and FRAC

Find more information: Pam Roy, New Mexico Food & Agriculture Policy Council, pam@farmtotabenm.org, 505-660-8403, https://nmfoodpolicy.org/

City of Santa Fe, New Mexico
Memorandum

Date: November 23, 2022

To: Quality of Life Committee, Public Works and Utilities Committee, Finance Committee, and Governing Body

From: Kyra Ochoa, Community Health and Safety Department Director KO

RE: Identifying City properties on which firearms are prohibited because the properties are used for school-sanctioned activities

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EXECUTIVE SUMMARY:

The proposed resolution identifies City property that is used for school-sanctioned activities and directs the City Manager to post signs that state that deadly weapons are prohibited.

BACKGROUND:

Between 1970 and June, 2022, there have been 2069 recorded school shootings. The New Mexico Constitution prohibits local governments from "regulat[ing], in any way, an incident of the right to keep or bear arms.".

NMSA 1978, Section 30-7-2.1, however, prohibits deadly weapons in "any...public buildings or grounds, including playing fields and parking areas that are not public school property, in or on which public school-related and sanctioned activities are being performed." A number of City properties fall into these categories. The proposed resolution directs the City Manager to post appropriate signage at relevant City locations that state deadly weapons are prohibited.

ATTACHMENTS:

Resolution
Fiscal Impact Report

CITY OF SANTA FE, NEW MEXICO

RESOLUTION NO. 2023-__

INTRODUCED BY:

Mayor Alan Webber

Councilor Amanda Chavez Councilor Jamie Cassutt

A RESOLUTION

RELATING TO FIREARMS; RECOGNIZING THAT CERTAIN CITY PROPERTIES ARE USED FOR SCHOOL-RELATED ACTIVITIES, WHICH MAKES THE CARRYING OF A DEADLY WEAPON ON SUCH PROPERTIES A FOURTH-DEGREE FELONY PURSUANT TO NMSA 1978, SECTION 30-7-2.1; AND DIRECTING THE CITY MANAGER TO WORK WITH STAFF TO POST NOTICE ON SUCH FACILITIES.

WHEREAS, NMSA 1978, Section 30-7-2.1 provides that unlawful carrying of a deadly weapon on school premises consists of carrying a deadly weapon on school premises except by a peace officer, school security personnel, authorized personnel in a military training corps program or state-authorized hunter safety training instruction, a person in a school-approved program that actively involves the carrying of a deadly weapon, or a person older than 19 in a private automobile for lawful protection of person or property; and

WHEREAS, included in the definition of school premises is "any…public buildings or grounds, including playing fields and parking areas that are not public school property, in or on which public school-related and sanctioned activities are being performed"; and

WHEREAS, whoever commits unlawful carrying of a deadly weapon on school premises is guilty of a fourth-degree felony; and

WHEREAS, a number of City-owned spaces, buildings, and other property are both governmental and used for school-related and sanctioned activities and therefore are "sensitive places" as identified by the U.S. Supreme Court; and

WHEREAS, according to the Naval Postgraduate Schools Center for Homeland Defense and Security, between 1970 and June, 2022, there have been 2069 school shootings; and

WHEREAS, those 2069 shootings have resulted in 684 fatalities and 1937 injuries: and

WHEREAS, of the 2069 school shootings, 985 have occurred since the tragic incident at Sandy Hook Elementary School nearly ten years ago in December, 2012; and

WHEREAS, according to the K-12 School Shooting Database, New Mexico has experienced 22 school shootings between 1971 and June, 2022, resulting in six deaths and 10 injuries; and

WHEREAS, in 2017, a 16-year-old student entered the Clovis-Carver Library in Clovis, NM and killed two people and wounded four others; and

WHEREAS, according to the Washington Post's school shootings database, more than 311,000 students at 331 schools have experienced gun violence at school since the Columbine High School shooting on April 20, 1999; and

WHEREAS, children who witness a shooting can be severely traumatized by the incident – trauma that can last a lifetime; and

WHEREAS, witnessing a shooting may impact the student's ability to continue studies, may impact a student's social and emotional growth, and may cause a student to become anxious or depressed; a student may even develop chronic psychiatric disorders as the result of witnessing a shooting; and

WHEREAS, since the shooting at Robb Elementary School in Uvalde, Texas, in which

19 second through fourth grade students and two teachers were killed, there have been 50 school shootings with four deaths and 32 injured.

NOW, THEREFORE, BE IT RESOLVED BY THE GOVERNING BODY OF THE CITY OF SANTA FE that the Governing Body recognizes that the following City locations are used for school-related or sanctioned events and therefore the carrying of deadly weapons on those properties is a fourth-degree felony under NMSA 1978, Section 30-7-2.1:

1. Santa Fe Community Convention Center and underground garage;
2. Municipal Recreation Complex soccer fields;
3. Genoveva Chavez Community Center;
4. Main library;
5. LaFarge library;
6. Southside library;
7. Facilities at which the Mayor's Youth Advisory Board holds their regular meetings;
7. Facilities to which students visit as part of a school-related or school-sanctioned activities including, but not limited to, the Buckman Direct Diversion; and
8. Facilities in which school interns are working, as placed through the Santa Fe Public Schools, including, but not limited to, City Hall and Municipal Court.

BE IT FURTHER RESOLVED that the City Manager shall direct staff to post signage at the locations listed above that states that deadly weapons are prohibited pursuant to NMSA 1978, Section 30-7-2.1.

BE IT FURTHER RESOLVED that, when the City Manager identifies additional City locations that are used for school-related or sanctioned events, the City Manager may direct staff to post signage at those locations and events to state that deadly weapons are prohibited pursuant to NMSA 1978, Section 30-7-2.1.

BE IT FURTHER RESOLVED the City Manager shall consult with the Community Health and Safety Department, including the Police Department, regarding the best method for enforcing NMSA 1978, Section 30-7-2.1 in relation to applicable City properties.

PASSED, APPROVED, and ADOPTED this _____day of _____, 2023.

_____

ALAN WEBBER, MAYOR

ATTEST:

_____

KRISTINE MIHELCIC, CITY CLERK

APPROVED AS TO FORM:

_____

ERIN K. McSHERRY, CITY ATTORNEY

Legislation/2023/Resolutions/Firearms on City Property that are School Premises

FIR No. 10429

FISCAL IMPACT REPORT

General Information:

(Check) **Bill:** _____ **Resolution:** X

Short Title(s): Firearms on City Property that are School Premises

Sponsor(s): Mayor Webber

Reviewing Department(s): Community Health and Safety

Staff Completing FIR: Kyra Ochoa KO **Date:** 9/7/22 **Phone:** 955-6603

Reviewed by City Attorney: _____ **Date:** Nov 24, 2022

Reviewed by Finance Director: _____ **Date:** _____

Summary:
The proposed resolution identifies various City facilities that are utilized by the Santa Fe Public Schools for school-sanctioned activities. The resolution also directs the City Manager to post signage at these locations stating deadly weapons are prohibited pursuant to State Statute (NMSA 1978, Section 30-7-2.1). This resolution responds to the continuing number of school shootings that have occurred around the country, with 2069 recorded school shootings between 1970 and June, 2022.

Departments Affected:
Community Health and Safety Department, Public Works Department

Consequences of Not Enacting Legislation:
If this legislation is not adopted, the City will not post signs at City facilities that are used for school-sanctioned activities stating deadly weapons are prohibited.

Conflict, Duplication, Companionship, or Relationship to Other Legislation:
None identified.

Performance and Administrative Implications:
Public Works Department will need to design, purchase, and install the necessary signs at the identified locations, as well as any subsequent City locations that are used for school-sanctioned activities.

Fiscal Implications:
The cost to purchase and install the signs is estimated at ~$20/per sign. The number of signs needed depends on the final locations and number of signs per location installed.

Fiscal Impact

_____ Check here if no fiscal impact

Expenditures

Expenditure Type	FYE 23	FYE 24	FYE 25	Require BAR (Y/N)	Recurring (R) or Non-recurring (NR)	Fund	3-Year Total Cost
Personnel and Benefits*	$	$	$				
Capital Outlay	$	$	$				
Contractual/ Professional Services	$	$	$				
Operating	$400	$	$		NR		$400
Total:	$400	$	$				$400

* This includes all staff time associated with executing the job functions of the proposed legislation.

Expenditure Narrative:

Posting the required signs is estimated at $20/sign for the locations specified in the Resolution. A minimum of 20 signs are estimated to be need for the identified locations. If additional locations are identified in the future there will be additional costs for those signs.

Revenue

Revenue Type	FYE __	FYE __	FYE __	Recurring (R) or Non-recurring (NR)	Fund
General Fund	$	$	$		
Special Revenue	$	$	$		
CIP	$	$	$		
Enterprise	$	$	$		
Internal Service	$	$	$		
Trust and Agency	$	$	$		
Federal	$	$	$		
Other	$	$	$		
Total	$	$	$		

Revenue Narrative:

Signature: Kyra Ochoa
Kyra Ochoa (Nov 23, 2022 12:17 MST)

Email: krochoa@santafenm.gov

15. INTRODUCTION OF LEGISLATION

c. CONSIDERATION OF RESOLUTION NO. 2023-__. (Mayor Webber)

A Resolution Relating to Firearms; Recognizing That Certain City Properties are Used for School-Related Activities, Which Makes the Carrying of a Deadly WEapon on Such Properties a Fourth-Degree Felony Pursuant to NMSA 1978, Section 30-7-2.1; and Directing the City Manager to Work with Staff to Post Notice on Such Facilities. (Kyra Ochoa, Community Health and Safety Department Director: krochoa@santafenm.gov)

Committee Review:

Introduced: 11/30/22
Quality of Life Committee: 12/7/22
Public Works and Utilities Committee: 12/12/22
Finance Committee: 01/03/23
Governing Body: 01/11/23

Name: Stefanie Beninato
Comment - 11/30/2022 09:54 AM: (No Vote)
How will this provision be enforced?

City of Santa Fe, New Mexico
Memorandum

Date: September 14, 2022

To: Governing Body

Via: Kyra Ochoa, Community Health and Safety Department Director KO
Regina Wheeler, Public Works Department Director RW
Rich Brown, Community Development Director

From: Romella Glorioso-Moss, AICP, Public Works Capital Projects Manager RGM

RE: Ordinance Amending Sections of the City of Santa Fe's UTO and Code

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ACTION:
Request for approval of a bill amending various sections of the Uniform Traffic Ordinance and the Santa Fe City Code related to bicycles to define and regulate electric bicycles or "e-bikes" on City roads and sidewalks.

BACKGROUND:
Electric bicycles, or "e-bikes," are becoming increasingly popular statewide, including in Santa Fe. The Santa Fe Metropolitan Planning Organization (SFMPO) estimated that between 30 to 40% of bicycles in our network are now electrified, compared to 10% or less prior to 2019. However, both the City and the State have no specific laws concerning e-bikes. The Bicycling and Pedestrian Advisory Committee (BPAC) recommends that the City leads the way in regulating e-bikes by providing a model for legislation by amending sections of the Uniform Traffic Ordinance and the Santa Fe City Code.

The proposed amendments include:
1) establishing a definition of an e-bike
2) specifying that e-bikes are not motor vehicles;
3) prohibiting anyone under the age of 16 riding a Class 3 e-bike
4) limiting speed limit of bicycles and e-bikes to 10 mph on City sidewalks
5) removing the prohibition for bicycles to ride on a street adjacent to a sidewalk or path when bicycles are required to use the sidewalk or street
6) making it an offense to modify an e-bike to enhance speed capabilities without proper labeling
7) raising the maximum fine from $25 to $100 for violating this ordinance.

This legislation is in line with the City's goal to have safe pedestrian and bicycle transportation networks. The ordinance currently states that "[n]o person shall operate a bicycle at a speed greater than is reasonable and prudent under the conditions then existing." This legislation would retain that provision and would also limit speeds on sidewalks to 10 miles per hour. Enforcement at speeds above 10 miles per hour and below 13 miles per hour will be difficult since the City's speed detection radars' lower limit is 10-13 mph. and since the radar that most officers have will detect speed of largest objects, like vehicles, in the area. Some officers have Lidar which could point directly at a bicycle and detect speeds In addition, wattage of an e-bike, which, in combination

with other features will cause a bike to be classified as a motor vehicle, cannot be detected prior to a stop and may not be discernable after a stop. Increased calls to dispatch may be difficult to respond to timely.

ATTACHMENTS:
Bill
Fiscal Impact Report

Signature:

Email:

Signature:

Email:

Signature:

Email:

Signature: Romella Glorioso-Moss
Romella Glorioso-Moss (Sep 14, 2022 13:09 MDT)

Email: rsglorioso-moss@santafenm.gov

CITY OF SANTA FE, NEW MEXICO

BILL NO. 2022-__

INTRODUCED BY:

Councilor Michael J. Garcia

Councilor Jamie Cassutt

underscored material = new [~~bracketed material~~] = delete

AN ORDINANCE

RELATING TO ELECTRIC BICYCLES; AMENDING SECTION 12-1-6 OF THE UNIFORM TRAFFIC ORDINANCE ("UTO") TO INCLUDE ELECTRIC BICYCLES IN THE DEFINITION OF BICYCLE; AMENDING SECTION 12-1-40 OF THE UTO TO DELINEATE ELECTRIC BICYCLES FROM MOTOR VEHICLES; AMENDING SECTION 12-1-88 OF THE UTO TO SPECIFY THAT AN ELECTRIC BICYCLE IS NOT A VEHICLE; AMENDING SECTION 12-8-1 OF THE UTO TO PROHIBIT ANYONE UNDER THE AGE OF SIXTEEN FROM RIDING A CLASS 3 ELECTRIC BICYCLE; AMENDING SECTION 12-8-10 OF THE UTO TO REGULATE AND ESTABLISH A SPEED LIMIT FOR ELECTRIC AND MANUALLY-PROPELLED BICYCLES ON CITY SIDEWALKS; AMENDING SECTION 12-8-15 OF THE UTO TO REMOVE THE PROHIBITION FOR BICYCLES TO RIDE ON A STREET ADJACENT TO A SIDEWALK OR PATH WHEN BICYCLES ARE REQUIRED TO USE THE SIDEWALK OR STREET; CREATING A NEW SECTION 12-8-18 OF THE UTO TO MAKE IT AN OFFENSE TO ENHANCE THE SPEED CAPABILITIES OF AN ELECTRIC BICYCLE; AMENDING SECTION 12-8-23 OF THE UTO TO RAISE THE MAXIMUM FINE FOR

VIOLATION OF CERTAIN PROVISIONS FROM TWENTY-FIVE DOLLARS TO ONE HUNDRED DOLLARS; AND AMENDING SFCC 1987 SECTION 23-5.1 TO AMEND THE DEFINITION OF BICYCLE TO INCLUDE ELECTRIC BICYCLES, AND TO REGULATE THE USE OF ELECTRIC BICYCLES ON CITY ROADS.

BE IT ORDAINED BY THE GOVERNING BODY OF THE CITY OF SANTA FE:

Section 1. Section 12-1-6 of the Uniform Traffic Ordinance (being Ord. No. 2011-23, § 1) is amended to read:

12-1-6 BICYCLE. "Bicycle" means:

A. Every device propelled by human power, upon which any person may ride, having two or more wheels, except scooters and similar devices[.];

B. Every device upon which a person may ride that is equipped with two or three wheels, pedals for human propulsion, and a motor of no more than seven hundred fifty (750) watts and meets the requirements of one of three classes:

(1) Class 1 electric bicycle means an electric bicycle equipped with a motor that provides assistance only when the rider is pedaling, and that ceases to provide assistance when the bicycle reaches the speed of twenty miles per hour (20 mph).

(2) Class 2 electric bicycle means a bicycle equipped with a motor that provides assistance to propel the bicycle even when the rider is not pedaling, and that is not capable of providing assistance when the bicycle reaches the speed of twenty miles per hour (20 mph).

(3) Class 3 electric bicycle means an electric bicycle equipped with a motor that provides assistance only when the rider is pedaling, and that ceases to provide assistance when the bicycle reaches the speed of twenty-eight miles per hour (28 mph).

C. Devices with motors outputting more than 750 watts or that can achieve a

maximum speed more than 28 mph on a paved level surface when powered solely by such a motor while ridden by an operator who weighs 170 pounds are motor vehicles.

D. Bicycles defined in paragraph B may also be referred to as “electric bicycles”

Section 2. Section 12-1-40 of the Uniform Traffic Ordinance (being Ord. No. 2011-23, § 1) is amended to read:

12-1-40 MOTOR VEHICLE. "Motor Vehicle" means every vehicle which is self-propelled and every vehicle which is propelled by electric power obtained from batteries, except electric bicycles, or from overhead trolley wires, but not operated upon rails; but for the purposes of the Mandatory Financial Responsibility Act [66-5-201 to 66-5-239 NMSA 1978], "motor vehicle” does not include "special mobile equipment." (66-1-4.11 NMSA 1978).

Section 3. Section 12-1-88 of the Uniform Traffic Ordinance (being Ord. No. 2011-23, § 1) is amended to read:

12-1-88 VEHICLE. "Vehicle" means every device in, upon, or by which, any person or property is or may be transported or drawn upon a street, including any frame, chassis, body or unitized frame and body of any vehicle or motor vehicle, except electric bicycles and devices moved by human power or used exclusively upon stationary rails or tracks. (66-1-4.19 NMSA 1978)

Section 4. Section 12-8-1 of the Uniform Traffic Ordinance (being Ord. No. 2011-23, § 1) is amended to read:

12-8-1 EFFECT OF REGULATIONS

A. It is a penalty assessment misdemeanor for a person to be any act forbidden or fail to perform any act required by Sections 12-8-1 through 23 of the Uniform Traffic Ordinance. (Ord. No. 2021-2, § 15)

B. [~~The parent of any child and the guardian of any ward~~]No person shall [~~not~~] authorize or permit any [~~such~~] child [~~or ward~~] to violate any of the provisions of this ordinance nor

shall any person permit any child under the age of sixteen (16) to operate a Class 3 electric bicycle. A person under the age of sixteen (16) may ride as a passenger on a Class 3 electric bicycle that is designed to accommodate passengers.

C. These regulations applicable to bicycles shall apply whenever a bicycle is operated upon any street, bicycle lane, or [~~upon any~~] path [~~set aside for the exclusive use of bicycles~~] subject to existing laws and those exceptions stated herein.

D. These provisions apply to the operation of bicycles and electric bicycles in the city of Santa Fe.

Section 5. Section 12-8-10 of the Uniform Traffic Ordinance (being Ord. No. 2011-23, § 1) is amended to read:

12-8-10 SPEED.

A. No person shall operate a bicycle at a speed greater than is reasonable and prudent under the conditions then existing.(*)

B. Where riding on sidewalks is allowed, bicycles shall be limited to ten (10) miles per hour.

Section 6. Section 12-8-7 of the Uniform Traffic Ordinance (being Ord. No. 2011-23, § 1) is amended to read:

12-8-15 RIDING ON SIDEWALKS

A. No person shall ride a bicycle on any sidewalk when signs are posted prohibiting the riding of bicycles on the sidewalk.

[~~B. When signs are posted requiring bicycles to use sidewalks or paths adjacent to a street, no person shall ride a bicycle on the street adjacent to the sidewalks or paths.~~]

[~~C~~]B. If the bicyclist dismounts, the bicyclist is subject to the laws that apply to pedestrians.

[~~D~~]C. Whenever any person is riding a bicycle upon a sidewalk the person shall yield the

right of way to any pedestrian. (Ord. #2011-23, §§ 22, 23)

Section 7. A new Section 12-8-18 of the Uniform Traffic Ordinance is hereby ordained to read:

12-8-18 ELECTRIC BICYCLE MODIFICATION. It is an offense for a person to knowingly modify an electric bicycle so as to change the speed capability of the electric bicycle and not appropriately replace, or cause to be replaced, the label indicating the class of the electric bicycle.

Section 8. Section 12-8-7 of the Uniform Traffic Ordinance (being Ord. No. 2011-23, § 1) is amended to read:

12-8-23 PENALTIES

A. Every person convicted of a violation of any provision of Section 12-8-1 through 12-8-23 shall be punished by a fine of not more than [~~twenty five dollars ($25.00)~~] one hundred dollars ($100.00).

Section 9. Section 23-5.1 of SFCC 1987 (being Ord. No. 1981-10, § 3, as amended) is amended to read:

23-5.1 Definitions.

As used in this chapter:

A. *Artist/artisan* means a person who designs and creates arts or crafts.

B. *Artwork* means an object for sale by an artist/artisan.

C. *Bicycle* means: [~~a vehicle with two (2) wheels tandem, a steering handle, a saddle seat, and pedals by which it is propelled~~]

(1) every device propelled by human power, upon which any person may ride, having two or more wheels, except scooters, skateboards, and similar devices; and

(2) every device propelled upon which a person may ride that is equipped with two or three wheels, pedals for human propulsion, and a motor of no more than

seven hundred fifty (750) watts whose maximum speed is no more than 28 mph on a paved level surface, when powered solely by such a motor.

D. *Canyon Road periphery area* means an area bounded by Paseo de Peralta on the west, the southern right-of-way line of East Alameda Street on the north, East Palace Avenue and Camino del Monte Sol on the east, and Canyon Road and Acequia Madre Street on the south. This area includes both sides of the boundary streets, except along the southern right-of-way line of East Alameda Street. (Editor's Note: A copy of the Canyon Road periphery area can be found at the end of this chapter.)

E. *Collective* means a nonprofit organization that shares the use of the license among three (3) to seven (7) nonrelated artists/artisans.

F. *Collective license* means a Plaza Park artist/artisan license issued to a collective.

G. *Commercial use* means any function or event at which goods, artwork, foodstuffs, merchandise of any kind are offered for sale.

H. *Community Days Festival* means a city sponsored event promoting the programs and services offered by local nonprofit organizations, performances by multicultural, youth, and school groups and celebrating the diversity of Santa Fe.

I. *Findings* mean mechanical fittings in a great variety, either commercially available or handmade, used to hold jewelry to the clothing or the person, i.e., ear wires, screw backs, broach pins, chains, gallery bezel wire or hollow beads.

J. *Handmade* means the design and creation of the artwork from raw materials and its finishing and decoration were accomplished by hand labor and by manually controlled methods that permit the maker to control and vary the construction shape, design and/or finish of each individual piece, but does not exclude the use of findings, hand tools and equipment nor does it exclude the hand assembly of premanufactured components in a creative manner.

K. *Immediate family* means the spouse, children and stepchildren of a Plaza Park

artist/artisan. The city may require proof of relationship for family members.

L. *Individual license* means a Plaza Park artist/artisan license issued to an individual artist/artisan licensee pursuant to the provisions of subsection 23-5.3 SFCC 1987.

M. *Machine made* means the producing or reproducing of artwork in mass production by mechanical processes such as stamping, blanking, weaving, molds or offset printing and other printing methods that allow mass production except as allowed by these regulations.

N. *Major commercial event* means any commercial use for which the entire Plaza is used.

O. *Minor rework* means taking a machine made or mass-produced item and making only minor additions or changes to the item.

P. *Noncommercial use* means any function or event at which nothing is offered for sale and at which no money or other valuable consideration is exchanged for goods or services. This use includes, but is not limited to, patriotic observances, political rallies, televised news media events and motion picture filming activities.

Q. *Nonprofit organization* means an organization that is registered as a New Mexico nonprofit organization with the New Mexico Public Regulatory Commission.

R. *Original* means the single, one (1) of a kind, master that can be used as the model for a reproduction.

S. *Plaza* means that inclusive area bounded on the north by the north curbline of Palace Avenue running in front of the Palace of the Governors, and on all other sides by the facades of the buildings, excluding portals, or property lines lying to the east, south and west of the Plaza Park as outlined in the map prepared by the city, labeled "Plaza Park Map." (Editor's Note: The Plaza Park Map may be found at the end of this chapter.)

T. *Plaza Park* means that inclusive area bounded by the inside back of the curb

surrounding the Plaza as outlined in the map prepared by the city, labeled "Plaza Park Map." (Editor's Note: The Plaza Park Map may be found at the end of this chapter.)

U. *Plaza Park artist/artisan* means an artist/artisan, or an artist/artisan represented by a collective issued a Plaza Park artist/artisan license.

V. *Plaza Park artist/artisan license* means a license issued to an artist/artisan by the city for the purpose of commercial sales on the Plaza Park.

W. *Plaza periphery area* means an area outside the Plaza Park, not including the Plaza Park, bounded by Sandoval and Grant Streets on the west, Alameda Street on the south, Paseo de Peralta on the east and Marcy Street on the north. This area includes both sides of the boundary streets.

X. *Plaza pushcart vendor* means a vendor who uses a non-permanent, non-motorized cart, barrow or unit that can be pushed by hand for the purpose of selling food products and is authorized by the city to be located in the Plaza Park, the Plaza, excluding the Plaza Park, or at any location in the Plaza periphery area.

Y. *Portrait artist* means a person who creates portraits, cartoons, caricatures, or silhouettes.

Z. *Portrait artist license* means a Plaza Park artist/artisan license issued to a portrait artist.

AA. *Pushcart* means a non-permanent, non-motorized cart, barrow or unit that can be pushed by hand.

BB. *Raw materials* mean any material that can be converted by manufacture or processing or a combination of manufacture and processing into a new and useful product.

CC. *Recreational object* means any object that can be thrown, kicked or struck, including, but not limited to, balls, frisbees or any object used in game or sport.

DD. *Reproduction* means the production of multiples of a single piece, the original or

master, applicable to each medium.

EE. *Resident of Santa Fe County* means a person whose primary residence is in Santa Fe County. Residency shall be established by any standard identification that proves residency such as a driver's license, passport or voter registration, utility bills or other documentation.

FF. *Roller skates or in-line skates* means a shoe with a set of wheels attached for skating over a flat surface.

GG. *Rotating license* means a Plaza Park artist/artisan license issued to seven (7) artists/artisans to be used on a rotating basis.

HH. *Service animal* means any animal trained to assist mobility of impaired, blind, or deaf people or trained for and actively employed by a police department.

II. *Skateboard* means a narrow board about two feet (2') long mounted on roller skate wheels.

JJ. *Special event* means an event that is permitted by the city pursuant to subsection 18-8.9 SFCC 1987, Section 23-4 SFCC 1987, subsection 23-5.2 SFCC 1987 or resolution of the governing body.

PASSED, APPROVED, and ADOPTED this _____day of _____, 2022.

_____

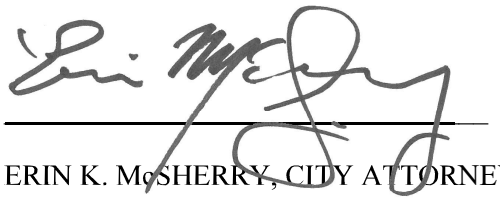
ALAN WEBBER, MAYOR

ATTEST:

_____

KRISTINE MIHELCIC, CITY CLERK

APPROVED AS TO FORM:



ERIN K. McSHERRY, CITY ATTORNEY

Legislation/2022/Bills/Establishing Electric Bicycle Definition

CITY OF SANTA FE, NEW MEXICO

BILL NO. 2022-__

INTRODUCED BY:

Councilor Michael J. Garcia

AN ORDINANCE

RELATING TO ELECTRIC BICYCLES; AMENDING SECTION 12-1-6 OF THE UNIFORM TRAFFIC ORDINANCE ("UTO") TO INCLUDE ELECTRIC BICYCLES IN THE DEFINITION OF BICYCLE; AMENDING SECTION 12-1-40 OF THE UTO TO DELINEATE ELECTRIC BICYCLES FROM MOTOR VEHICLES; AMENDING SECTION 12-1-88 OF THE UTO TO SPECIFY THAT AN ELECTRIC BICYCLE IS NOT A VEHICLE; AMENDING SECTION 12-8-1 OF THE UTO TO PROHIBIT ANYONE UNDER THE AGE OF SIXTEEN FROM RIDING A CLASS 3 ELECTRIC BICYCLE; AMENDING SECTION 12-8-10 OF THE UTO TO REGULATE AND ESTABLISH A SPEED LIMIT FOR ELECTRIC AND MANUALLY-PROPELLED BICYCLES ON CITY SIDEWALKS; AMENDING SECTION 12-8-15 OF THE UTO TO REMOVE THE PROHIBITION FOR BICYCLES TO RIDE ON A STREET ADJACENT TO A SIDEWALK OR PATH WHEN BICYCLES ARE REQUIRED TO USE THE SIDEWALK OR STREET; CREATING A NEW SECTION 12-8-18 OF THE UTO TO MAKE IT AN OFFENSE TO ENHANCE THE SPEED CAPABILITIES OF AN ELECTRIC BICYCLE; AMENDING SECTION 12-8-23 OF THE UTO TO RAISE THE MAXIMUM FINE FOR

underscored material = new [~~bracketed material~~] = delete

VIOLATION OF CERTAIN PROVISIONS FROM TWENTY-FIVE DOLLARS TO ONE HUNDRED DOLLARS; AND AMENDING SFCC 1987 SECTION 23-5.1 TO AMEND THE DEFINITION OF BICYCLE TO INCLUDE ELECTRIC BICYCLES, AND TO REGULATE THE USE OF ELECTRIC BICYCLES ON CITY ROADS.

BE IT ORDAINED BY THE GOVERNING BODY OF THE CITY OF SANTA FE:

Section 1. Section 12-1-6 of the Uniform Traffic Ordinance (being Ord. No. 2011-23, § 1) is amended to read:

12-1-6 BICYCLE. "Bicycle" means:

A. Every device propelled by human power, upon which any person may ride, having two or more wheels, except scooters and similar devices[.];

B. Every device upon which a person may ride that is equipped with two or three wheels, pedals for human propulsion, and a motor of no more than seven hundred fifty (750) watts and meets the requirements of one of three classes:

(1) Class 1 electric bicycle means an electric bicycle equipped with a motor that provides assistance only when the rider is pedaling, and that ceases to provide assistance when the bicycle reaches the speed of twenty miles per hour (20 mph).

(2) Class 2 electric bicycle means a bicycle equipped with a motor that provides assistance to propel the bicycle even when the rider is not pedaling, and that is not capable of providing assistance when the bicycle reaches the speed of twenty miles per hour (20 mph).

(3) Class 3 electric bicycle means an electric bicycle equipped with a motor that provides assistance only when the rider is pedaling, and that ceases to provide assistance when the bicycle reaches the speed of twenty-eight miles per hour (28 mph).

C. Devices with motors outputting more than 750 watts or that can achieve a

maximum speed more than 28 mph ~~on a paved level surface when powered solely by such a motor while ridden by an operator who weighs 170 pounds~~ are motor vehicles.

D. Bicycles defined in paragraph B may also be referred to as “electric bicycles”

Section 2. Section 12-1-40 of the Uniform Traffic Ordinance (being Ord. No. 2011-23, § 1) is amended to read:

12-1-40 MOTOR VEHICLE. "Motor Vehicle" means every vehicle which is self-propelled and every vehicle which is propelled by electric power obtained from batteries, except electric bicycles, or from overhead trolley wires, but not operated upon rails; but for the purposes of the Mandatory Financial Responsibility Act [66-5-201 to 66-5-239 NMSA 1978], "motor vehicle” does not include "special mobile equipment." (66-1-4.11 NMSA 1978).

Section 3. Section 12-1-88 of the Uniform Traffic Ordinance (being Ord. No. 2011-23, § 1) is amended to read:

12-1-88 VEHICLE. "Vehicle" means every device in, upon, or by which, any person or property is or may be transported or drawn upon a street, including any frame, chassis, body or unitized frame and body of any vehicle or motor vehicle, except ~~electric bicycles and~~ devices moved by human power or used exclusively upon stationary rails or tracks. ~~(66-1-4.19 NMSA 1978)~~ Electric bicycles are vehicles.

Section 4. Section 12-8-1 of the Uniform Traffic Ordinance (being Ord. No. 2011-23, § 1) is amended to read:

12-8-1 EFFECT OF REGULATIONS

A. It is a penalty assessment misdemeanor for a person to be any act forbidden or fail to perform any act required by Sections 12-8-1 through 23 of the Uniform Traffic Ordinance. (Ord. No. 2021-2, § 15)

B. [~~The parent of any child and the guardian of any ward~~]No person shall [~~not~~] authorize or permit any [~~such~~] child [~~or ward~~] to violate any of the provisions of this ordinance nor

shall any person permit any child under the age of sixteen (16) to operate a Class 3 electric bicycle. A person under the age of sixteen (16) may ride as a passenger on a Class 3 electric bicycle that is designed to accommodate passengers.

C. These regulations applicable to bicycles shall apply whenever a bicycle is operated upon any street, bicycle lane, or [~~upon any~~] path [~~set aside for the exclusive use of bicycles~~] subject to existing laws and those exceptions stated herein.

D. These provisions apply to the operation of bicycles and electric bicycles in the city of Santa Fe.

Section 5. Section 12-8-10 of the Uniform Traffic Ordinance (being Ord. No. 2011-23, § 1) is amended to read:

12-8-10 SPEED.

A. No person shall operate a bicycle at a speed greater than is reasonable and prudent under the conditions then existing.(*)

B. Where riding on sidewalks is allowed, bicycles shall be limited to ten (10) miles per hour.

Section 6. Section 12-8-7 of the Uniform Traffic Ordinance (being Ord. No. 2011-23, § 1) is amended to read:

12-8-15 RIDING ON SIDEWALKS

A. No person shall ride a bicycle on any sidewalk when signs are posted prohibiting the riding of bicycles on the sidewalk.

[~~B. When signs are posted requiring bicycles to use sidewalks or paths adjacent to a street, no person shall ride a bicycle on the street adjacent to the sidewalks or paths.~~]

[~~C~~]B. If the bicyclist dismounts, the bicyclist is subject to the laws that apply to pedestrians.

[~~D~~]C. Whenever any person is riding a bicycle upon a sidewalk the person shall yield the

right of way to any pedestrian. (Ord. #2011-23, §§ 22, 23)

Section 7. A new Section 12-8-18 of the Uniform Traffic Ordinance is hereby ordained to read:

12-8-18 ELECTRIC BICYCLE MODIFICATION. It is an offense for a person to knowingly modify an electric bicycle so as to change the speed capability of the electric bicycle and not appropriately replace, or cause to be replaced, the label indicating the class of the electric bicycle.

Section 8. Section 12-8-7 of the Uniform Traffic Ordinance (being Ord. No. 2011-23, § 1) is amended to read:

12-8-23 PENALTIES

A. Every person convicted of a violation of any provision of Section 12-8-1 through 12-8-23 shall be punished by a fine of not more than [~~twenty five dollars ($25.00)~~] one hundred dollars ($100.00).

Section 9. Section 23-5.1 of SFCC 1987 (being Ord. No. 1981-10, § 3, as amended) is amended to read:

23-5.1 Definitions.

As used in this chapter:

A. *Artist/artisan* means a person who designs and creates arts or crafts.

B. *Artwork* means an object for sale by an artist/artisan.

C. *Bicycle* means: [~~a vehicle with two (2) wheels tandem, a steering handle, a saddle seat, and pedals by which it is propelled~~]

(1) every device propelled by human power, upon which any person may ride, having two or more wheels, except scooters, skateboards, and similar devices; and

(2) every device propelled upon which a person may ride that is equipped with two or three wheels, pedals for human propulsion, and a motor of no more than

seven hundred fifty (750) watts whose maximum speed is no more than 28 mph ~~on a paved level surface, when powered solely by such a motor~~.

D. *Canyon Road periphery area* means an area bounded by Paseo de Peralta on the west, the southern right-of-way line of East Alameda Street on the north, East Palace Avenue and Camino del Monte Sol on the east, and Canyon Road and Acequia Madre Street on the south. This area includes both sides of the boundary streets, except along the southern right-of-way line of East Alameda Street. (Editor's Note: A copy of the Canyon Road periphery area can be found at the end of this chapter.)

E. *Collective* means a nonprofit organization that shares the use of the license among three (3) to seven (7) nonrelated artists/artisans.

F. *Collective license* means a Plaza Park artist/artisan license issued to a collective.

G. *Commercial use* means any function or event at which goods, artwork, foodstuffs, merchandise of any kind are offered for sale.

H. *Community Days Festival* means a city sponsored event promoting the programs and services offered by local nonprofit organizations, performances by multicultural, youth, and school groups and celebrating the diversity of Santa Fe.

I. *Findings* mean mechanical fittings in a great variety, either commercially available or handmade, used to hold jewelry to the clothing or the person, i.e., ear wires, screw backs, broach pins, chains, gallery bezel wire or hollow beads.

J. *Handmade* means the design and creation of the artwork from raw materials and its finishing and decoration were accomplished by hand labor and by manually controlled methods that permit the maker to control and vary the construction shape, design and/or finish of each individual piece, but does not exclude the use of findings, hand tools and equipment nor does it exclude the hand assembly of premanufactured components in a creative manner.

K. *Immediate family* means the spouse, children and stepchildren of a Plaza Park

artist/artisan. The city may require proof of relationship for family members.

L. *Individual license* means a Plaza Park artist/artisan license issued to an individual artist/artisan licensee pursuant to the provisions of subsection 23-5.3 SFCC 1987.

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HH. *Service animal* means any animal trained to assist mobility of impaired, blind, or deaf people or trained for and actively employed by a police department.

II. *Skateboard* means a narrow board about two feet (2') long mounted on roller skate wheels.

JJ. *Special event* means an event that is permitted by the city pursuant to subsection 18-8.9 SFCC 1987, Section 23-4 SFCC 1987, subsection 23-5.2 SFCC 1987 or resolution of the governing body.

PASSED, APPROVED, and ADOPTED this _____day of _____, 2022.

_____

ALAN WEBBER, MAYOR

ATTEST:

_____

KRISTINE MIHELCIC, CITY CLERK

APPROVED AS TO FORM:

_____

ERIN K. McSHERRY, CITY ATTORNEY

FIR No. 10389

FISCAL IMPACT REPORT

General Information:

(Check) Bill: X Resolution: _____

Short Title(s): Establishing Electric Bicycle Definition

Sponsor(s): Councilor Michael Garcia

Reviewing Department(s): Public Works and Utilities

Staff Completing FIR: Romella Glorioso-Moss RGM Date: 08/23/2022 Phone: 955-6623

Reviewed by City Attorney: _____ Date: _____

Reviewed by Finance Director: Emily K. Oster Date: Sep 15, 2022
Emily K. Oster (Sep 15, 2022 15:34 MDT)

Summary:
Electric bicycles or "e-bikes" are becoming increasingly popular statewide including in the City of Santa Fe ("City"). However, both the City and State do not regulate e-bike use. The Bicycling and Pedestrian Advisory Committee ("BPAC") recommends that the City leads the way in regulating e-bikes by providing a model for legislation by amending sections of the Uniform Traffic Ordinance and the Santa Fe City Code.

Departments Affected:
Public Works Department, Community Health and Safety Department.

Consequences of Not Enacting Legislation:
If the legislation is not adopted, safety of all road users, especially the vulnerable ones such as bicyclists and pedestrians, may be at higher risk of an accident and injury.

Conflict, Duplication, Companionship, or Relationship to Other Legislation:
None identified.

Performance and Administrative Implications:
If adopted, the bill will provide increased clarity for the police on how to regulate e-bikes. Enforcement is challenging.

Fiscal Implications:
The bill increases the maximum amount that a violator of Section 12-8 of the UTO could be fined from $25 to $100. Because the fine levied by the Municipal Judge can vary, it is not possible to determine the fiscal impact of the change. Police Department and Public Works Departments do not foresee additional expenditures associated with this ordinance at this time.

Fiscal Impact

X Check here if no fiscal impact

Expenditures

Expenditure Type	FYE __	FYE __	FYE __	Require BAR (Y/N)	Recurring (R) or Non-recurring (NR)	Fund	3-Year Total Cost
Personnel and Benefits*	$	$	$				
Capital Outlay	$	$	$				
Contractual/ Professional Services	$	$	$				
Operating	$	$	$				$
Total:	$	$	$				$

* This includes all staff time associated with executing the job functions of the proposed legislation.

Expenditure Narrative:

None identified.

Revenue

Revenue Type	FYE __	FYE __	FYE __	Recurring (R) or Non-recurring (NR)	Fund
General Fund	$	$	$		
Special Revenue	$	$	$		
CIP	$	$	$		
Enterprise	$	$	$		
Internal Service	$	$	$		
Trust and Agency	$	$	$		
Federal	$	$	$		
Other	$	$	$		
Total	$	$	$		

Revenue Narrative:

None identified.

Signature: Regina Wheeler
Regina Wheeler (Sep 16, 2022 13:09 MDT)

Email: rawheeler@santafenm.gov

Signature:
Kyra Ochoa (Sep 16, 2022 05:33 MDT)

Email: krochoa@santafenm.gov

Signature: Richard Brown

Email: rdbrown@santafenm.gov

Signature: Romella Glorioso-Moss
Romella Glorioso-Moss (Sep 15, 2022 07:31 MDT)

Email: rsglorioso-moss@santafenm.gov

VOTE SUMMARY

City of Santa Fe

Meeting Name - Quality of Life Committee

Meeting Start Date - 10/19/2022

Meeting Committee - Quality of Life Committee

Item Title - CONSIDERATION OF BILL NO. 2022-__. (Councilor M. Garcia)
An Ordinance Relating to Electric Bicycles; Amending Section 12-1-6 of the Uniform Traffic Ordinance ("UTO") to Include Electric Bicycles in the Definition of Bicycle; Amending Section 12-1-40 of the UTO to Delineate Electric Bicycles From Motor Vehicles; Amending Section 12-1-88 of the UTO to Specify That an Electric Bicycle is Not a Vehicle; Amending Section 12-8-1 of the UTO to Prohibit Anyone Under the Age of Sixteen From Riding a Class 3 Electric Bicycle; Amending Section 12-8-10 of the UTO to Regulate and Establish a Speed Limit for Electric and Manually-Propelled Bicycles on City Sidewalks; Amending Section 12-8-15 of the UTO to Remove the Prohibition for Bicycles to Ride on a Street Adjacent to a Sidewalk or Path When Bicycles are Required to Use the Sidewalk or Street; Creating a New Section 12-8-18 of the UTO to Make it an Offense to Enhance the Speed Capabilities of an Electric Bicycle; Amending Section 12-8-23 of the UTO to Raise the Maximum Fine for Violation of Certain Provisions from Twenty-Five Dollars to One Hundred Dollars; and Amending SFCC 1987 Section 23-5.1 to Amend the Definition of Bicycle to Include Electric Bicycles, and to Regulate the Use of Electric Bicycles on City Roads. (Romella Glorioso-Moss; Project Administrator: rsglorioso-moss@santafenm.gov, 505-955-6623; Kevin Nault, Assistant City Attorney: klnault@santafenm.gov)

Committee Review:
Governing Body (Introduced): 08/31/2022
Governing Body (Public Comment): 09/14/2022
Bicycle and Pedestrian Advisory Committee: 10/13/2022
Quality of Life Committee: 10/19/2022
Bicycle and Pedestrian Advisory Committee: 11/10/2022
Quality of Life Committee: 12/7/2022
Public Works and Utilities Committee: 12/12/2022
Finance Committee: 01/09/2023
Governing Body (Public Hearing): 01/11/2023

Item Type - bill

Item Owner - Romella Glorioso-Moss

Item Sponsor - Michael Garcia

Item Tracking Number - 22-15057-02

VOTE SUMMARY

City of Santa Fe

Motion Type - Approve

Motion Mover - Renee Villarreal

Motion Seconder - Amanda Chavez

Motion Status -

Vote For Count - 5

Vote Against Count - 0

Vote Abstain Count - 0

Vote Absent Count - 0

Vote For Names - Amanda Chavez, Lee Garcia, Michael Garcia, Jamie Cassutt, Renee Villarreal

Vote Against Names -

Vote Abstain Names -

Vote Absent Names -

User Name - Elizabeth Martin

User Email - max4martin@yahoo.com

CITY OF SANTA FE, NEW MEXICO
PROPOSED AMENDMENT(S) TO BILL NO. 2022-__
Establishing Electric Bicycle Definition

Mayor and Members of the City Council:

I propose the following amendment(s) to Bill No. 2022-__:

1. On page 3, lines 1-2, ***strike*** between “mph” and “are motor vehicles”.
2. On page 3, line 15, strike the insertion "electric bicycles and"
3. On page 3, line 16, after the period ***insert*** the following new sentence: “Electric bicycles are vehicles.” and ***strike*** “(66-1-4.19 NMSA 1978)”.
4. On page 6, lines 1-2, after “mph” ***strike*** the remainder of the sentence.

Respectfully submitted,

_____
Michael J. Garcia, Councilor

Approved as to Form:

_____
Erin K. McSherry, City Attorney

ADOPTED: _____
NOT ADOPTED: _____
DATE: _____

_____
Kristine Mihelcic, City Clerk