

City of Santa Fe, New Mexico

memo

DATE: April 13, 2015

TO: Finance Committee

FROM: Robert Rodarte, Officer
Purchasing Division *RR*

ISSUE: Information and Update of Award of Request for Proposal # '15/24/P
Third Party Administration for Self-Funded Employee Medical Plan Stop Loss
Coverage Flexible Spending Account (FSA) Administration COBRA Administration
Wellness Program Voluntary Vision Insurance Coverage

SUMMARY:

On February 23, 2015, ten proposals were received for the above referenced service; only four proposals met all the required criteria and were evaluated as follows:

	Evaluation 1 st Round	Evaluation 2 nd Round
Cigna, CO	3865	765
United Healthcare Group, CT	2770	620
Blue Cross Blue Shield, Albuquerque	2570	
Presbyterian, Albuquerque	2320	

The evaluation criteria consisted of medical claims administration (35%); PPO network (40%); medical cost management (20%); dedicated account executive/manager (10%); pertinent experience (10%); administrative fees (20%) wellness program (20%); FSA Administration (10%); stop loss (10%); and COBRA (10%). The proposal was reviewed and evaluated by Sandra Perez, Director, Victoria Gage, Assistant Director, Colleen Higgins Vigil, Benefits Administrator, Human Resources, Teresita Garcia, Assistant Director, Finance and David Pelly Hutton, Fire Fighter Union Representative. Consulting representatives from AON Risk Solutions assisted the committee during the selection process.

The entire selection and interview process consisted of Matt Martinez, Eric Sanchez, Representative, Charles Lujan, Police Union Representatives, Patrick Romero, ASFME Union Representative, Fire Fighter Union Representative, Nick Schiavo, Director, Public Utilities Department, Management Representative, Teresita Garcia, Assistant Director, Finance, Management Representative, Sandra Perez, Director, Victoria Gage, Assistant Director, Colleen Higgins Vigil, Benefits Administrator, Human Resources, Robert Rodarte, Purchasing Officer and AON Risk Solution Representatives.

All committee members understood the purpose of the RFP process was to select a qualified company to administer the City's Health Care Plan. The upcoming changes to the plan are not part of the evaluation criteria. All costs and administrative changes to the plan will reflect the negotiated contract to be presented at the April 29, 2015 City Council. The using committee has reviewed the proposals and recommends award to Cigna, CO. It is requested that this recommendation of award to Cigna, Co, be reviewed, approved and submitted to the City Council for its consideration.

Attachment(s):

1. A copy of tabulation score sheet.

EVALUATION SCORES

Third Party Administration for Self-Funded Employee Medical Plan Stop Loss Coverage Flexible Spending Account (FSA) Administration COBRA Administration Wellness Program Voluntary Vision Insurance Coverage

'15/24/P

Evaluation 1st Round

Evaluation Committee Members	Cigna	United Health Group	Blue Cross Blue Shield	Presbyterian
Sandra Perez	765	580	515	460
Victoria Gage	805	500	420	360
Colleen Higgins Vigil	765	565	515	480
Teresita Garcia	765	545	605	520
Pelly Hutton	765	580	515	500
Total Score	3865	2770	2570	2320

Evaluation 2nd Round

Cigna	United Health Group
765	620

*Finalist
Score Sheet*

**EVALUATION CRITERIA & WEIGHTED VALUES
'15/24/P**

- Administration for Self-Funded Medical Plan
- Stop Loss Coverage
- Spending Account (FSA) Administration
- COBRA Administration
- Wellness Program
- Voluntary Vision Insurance Coverage

Date: 4/7/15

Name: Screening Team

Firm: CIGNA

[Signature]
Signature and Title of Evaluation Committee Member

[Signature] SFFD
[Signature] Geneva
[Signature] AR
[Signature] C Higgins
[Signature] Patrick Roman AFSCME

Please "x" one: Proposal Review _____ Interview X

Proposal Component	Weighted Value	Evaluation Points 1 thru 5	Total Score	Max Score
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SECTION A – Medical Insurance Administration

Medical Claims Administration	35%	x	<u>5</u>	<u>175</u>	175
PPO Network	40%	x	<u>4</u>	<u>160</u>	200
Medical Cost Management	20%	x	<u>5</u>	<u>100</u>	100
Dedicated account executive/manager	10%	x	<u>5</u>	<u>50</u>	50
Pertinent experience of vendor & staff expertise	10%	x	<u>5</u>	<u>50</u>	50
Administrative Fees	20%	x	<u>5</u>	<u>100</u>	100
Wellness Program	20%	x	<u>5</u>	<u>100</u>	100
FSA Administration	10%	x	_____	_____	50
Stop Loss	10%	x	<u>3</u>	<u>30</u>	50
COBRA	10%	x	_____	_____	50
Total Points				<u>765</u>	925 825

Analyst
Score Sheet

EVALUATION CRITERIA & WEIGHTED VALUES
'15/24/P

- Administration for Self-Funded Medical Plan
- Stop Loss Coverage
- Spending Account (FSA) Administration
- COBRA Administration
- Wellness Program
- Voluntary Vision Insurance Coverage

Date: 4/7/15

Name: Screening sheet

Firm: Utta

[Signature]
Signature and Title of Evaluation Committee Member

[Signature] SFFD
[Signature]
Chiguis Val
Jesús Juan
Patricia M. AFSCME

Please "x" one: Proposal Review _____ Interview X

Proposal Component	Weighted Value	Evaluation Points 1 thru 5	Total Score	Max Score
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SECTION A – Medical Insurance Administration

①	Medical Claims Administration	35% x	<u>4</u>	<u>140</u>	175
②	PPO Network	40% x	<u>4</u>	<u>160</u>	200
③	Medical Cost Management	20% x	<u>3</u>	<u>60</u>	100
④	Dedicated account executive/manager	10% x	<u>5</u>	<u>50</u>	50
⑤	Pertinent experience of vendor & staff expertise	10% x	<u>3</u>	<u>30</u>	50
⑥	Administrative Fees	20% x	<u>4</u>	<u>80</u>	100
⑦	Wellness Program	20% x	<u>4</u>	<u>80</u>	100
	FSA Administration	10% x	_____	_____	50
⑧	Stop Loss	10% x	<u>2</u>	<u>20</u>	50
	COBRA	10% x	_____	_____	50
	Total Points			<u>620</u>	<u>825</u>

City of Santa Fe, New Mexico

memo

DATE: April 13, 2015

TO: Finance Committee

FROM: Robert Rodarte, Officer
Purchasing Division *RR*

ISSUE: Information and Update of Award of Request for Proposal # '15/25/P
Dental Benefit Plan

SUMMARY:

On February 23, 2015, six proposals were received for the above referenced service as follows:

	Evaluation 1 st Round	Evaluation 2 nd Round
Cigna, CO	1955	430
Delta Dental, Albuquerque	2115	360
United Concordia, AZ	2085	300
Blue Cross Blue Shield, Albuquerque	1935	
United Health Group, CT	1605	
Metlife, IL	1395	

The evaluation criteria consisted of dental claims administration fees (35%); provider network (35%); and ease of eligibility maintenance (35%). The proposal was reviewed and evaluated by Sandra Perez, Director, Victoria Gage, Assistant Director, Colleen Higgins Vigil, Benefits Administrator, Human Resources, Teresita Garcia, Assistant Director, Finance and David Pelly Hutton, Fire Fighter Union Representative. Consulting representatives from AON Risk Solutions assisted the committee during the selection process.

The entire selection and interview process consisted of Matt Martinez, Eric Sanchez, Representative, Charles Lujan, Police Union Representatives, Patrick Romero, ASFME Union Representative, Fire Fighter Union Representative, Nick Schiavo, Director, Public Utilities Department, Management Representative, Teresita Garcia, Assistant Director, Finance, Management Representative, Sandra Perez, Director, Victoria Gage, Assistant Director, Colleen Higgins Vigil, Benefits Administrator, Human Resources, Robert Rodarte, Purchasing Officer and AON Risk Solution Representatives.

All committee members understood the purpose of the RFP process was to select a qualified company to administer the City's Health Care Plan. The upcoming changes to the plan are not part of the evaluation criteria. All costs and administrative changes to the plan will reflect the negotiated contract to be presented at the April 29, 2015 City Council. The using committee has reviewed the proposals and recommends award to Cigna, CO. It is requested that this recommendation of award to Cigna, Co, be reviewed, approved and submitted to the City Council for its consideration.

Attachment(s):

1. A copy of tabulation score sheet.

EVALUATION SCORES
DENTAL BENEFIT PLAN

'15/25/P

Evaluation 1st Round

Evaluation Committee Members	Delta Dental	United Concordia	Cigna	Blue Cross Blue Shield	United Health Group	Metlife
Sandra Perez	430	405	465	400	370	300
Victoria Gage	430	405	465	400	370	300
Colleen Higgins Vigil	465	440	200	300	130	200
Teresita Garcia	430	400	465	400	370	300
Pelly Hutton	360	435	400	435	365	295
Total Score	2115	2085	1955	1935	1605	1395

Evaluation 2nd Round

Cigna	Delta Dental	United Concordia
430	360	300

Evaluation Scores for '15/25/P', Dental Benefit Plan

Evaluators:	Sandra Perez		Victoria Gage		Colleen Higgins Virgil		Terestia Garcia		Pelly Hutton	
	Evaluation Points	Score	Evaluation Points	Score	Evaluation Points	Score	Evaluation Points	Score	Evaluation Points	Score
Firm: Delta Dental										
Criteria	0-1-2-3-4-5		0-1-2-3-4-5		0-1-2-3-4-5		0-1-2-3-4-5		0-1-2-3-4-5	
Dental Claims Administration Fees	3	105	3	105	5	175	3	105	2	70
Provider Network	5	175	5	175	4	140	5	175	4	140
Ease of Eligibility Maintenance	5	150	5	150	5	150	5	150	5	150
Total		430		430		465		430		360
Firm: United Concordia										
Criteria	0-1-2-3-4-5		0-1-2-3-4-5		0-1-2-3-4-5		0-1-2-3-4-5		0-1-2-3-4-5	
Dental Claims Administration Fees	5	175	5	175	5	175	4	140	4	140
Provider Network	4	140	4	140	5	175	4	140	5	175
Ease of Eligibility Maintenance	3	90	3	90	3	90	4	120	4	120
Total		405		405		440		400		435
Firm: Cigna										
Criteria	0-1-2-3-4-5		0-1-2-3-4-5		0-1-2-3-4-5		0-1-2-3-4-5		0-1-2-3-4-5	
Dental Claims Administration Fees	5	175	5	175	2	70	5	175	4	140
Provider Network	4	140	4	140	2	70	4	140	4	140
Ease of Eligibility Maintenance	5	150	5	150	2	60	5	150	4	120
Total		465		465		200		465		400
Firm: Blue Cross Blue Shield										
Criteria	0-1-2-3-4-5		0-1-2-3-4-5		0-1-2-3-4-5		0-1-2-3-4-5		0-1-2-3-4-5	
Dental Claims Administration Fees	5	175	5	175	3	105	5	175	5	175
Provider Network	3	105	3	105	3	105	3	105	4	140
Ease of Eligibility Maintenance	4	120	4	120	3	90	4	120	4	120
Total		400		400		300		400		435
Firm: United Health Group										
Criteria	0-1-2-3-4-5		0-1-2-3-4-5		0-1-2-3-4-5		0-1-2-3-4-5		0-1-2-3-4-5	
Dental Claims Administration Fees	4	140	4	140	1	35	4	140	3	105
Provider Network	4	140	4	140	1	35	4	140	4	140
Ease of Eligibility Maintenance	3	90	3	90	2	60	3	90	4	120
Total		370		370		130		370		365
Firm: MetLife										
Criteria	0-1-2-3-4-5		0-1-2-3-4-5		0-1-2-3-4-5		0-1-2-3-4-5		0-1-2-3-4-5	
Dental Claims Administration Fees	2	70	2	70	2	70	2	70	1	35
Provider Network	4	140	4	140	2	70	4	140	4	140
Ease of Eligibility Maintenance	3	90	3	90	2	60	3	90	4	120
Total		300		300		200		300		295
Overall Scores		Average		Average		Average		Average		Average
		112		112		112		112		112
		560		560		560		560		560
		805		805		805		805		805
		750		750		750		750		750
		423		423		423		423		423
		2,115		2,115		2,115		2,115		2,115
Overall Scores		Average		Average		Average		Average		Average
		161		161		161		161		161
		805		805		805		805		805
		770		770		770		770		770
		510		510		510		510		510
		417		417		417		417		417
		1,995		1,995		1,995		1,995		1,995
Overall Scores		Average		Average		Average		Average		Average
		112		112		112		112		112
		560		560		560		560		560
		595		595		595		595		595
		450		450		450		450		450
		321		321		321		321		321
		1,605		1,605		1,605		1,605		1,605
Overall Scores		Average		Average		Average		Average		Average
		63		63		63		63		63
		315		315		315		315		315
		126		126		126		126		126
		90		90		90		90		90
		279		279		279		279		279
		1,395		1,395		1,395		1,395		1,395

FIRM	Total Score	Rank
Firm: Delta Dental	423	1
Firm: United Concordia	417	2
Firm: Cigna	399	3
Firm: Blue Cross Blue Shield	387	4
Firm: United Health Group	321	5
Firm: MetLife	279	6

Delta

35% Admin fee	1	35	35%	Base of Eligibility
			35%	
			Provider	
			MS	
			MS	
			5	5
				150
				360

↑ \$1500 \$370

WCS

	2	70	3	90	300
			4	140	

↓ \$1500 \$350

Cigna

	3	100	4	140	5	150	390
		\$345					
	4	140	4	140	5	150	430

↓ Bundled score if needed. ~~PHD~~ SFFD

Sevada Garcia Victoria Lopez Chiguis-Lizid

Salud / C ASOME

City of Santa Fe, New Mexico

memo

DATE: April 23, 2015

TO: Governing Body

FROM: Lynette Trujillo, Director 
Human Resources Department

ITEM: Request Approval for Award of Requests for Proposal # '15/24/P and # '15/25/P - CIGNA

BACKGROUND AND SUMMARY:

On January 11, 2015, the City of Santa Fe issued the following Requests for Proposal:

# '15/24/P	Third Party Administration for Self-Funded Employee Medical Plan Stop Loss Insurance Flexible Spending Account (FSA) Administration COBRA Administration Wellness Program Voluntary Vision Insurance Coverage
# '15/25/P	Dental Benefit Plan

After a thorough and comprehensive evaluation process by the RFP Selection Committee, Cigna was selected for recommendation to the Governing Body for the award of RFP #'s '15/24/P BS '15/25/P. Cigna scored the highest in the evaluation criteria as specified in each RFP.

If approved, Cigna will provide the City of Santa Fe with the Third Party administration for the City's self-funded medical and dental insurance programs along with the administration of the FSA and COBRA programs. Cigna will also provide individual and aggregate stop loss insurance coverage and the voluntary vision insurance coverage.

Cigna has demonstrated that there will be minimal disruption to employees and covered dependents due to their nationwide network of contracted medical and dental providers. Cigna is also offering a very strong wellness support program that will complement the efforts of the City's Wellness Coordinator by providing clinical resources and programs along with a wellness credit of \$100,000 for each year of the proposed contract (\$400,000). The programs include onsite biometric screenings, onsite classes, seminars, challenge programs, special events, and incentives for participation.

Combining Cigna's medical, dental, and vision insurance programs will help optimize the City's desired health outcomes and savings because Cigna will have access to the member's integrated dental, vision, and medical data. Cigna will have the ability to provide a more holistic outreach to those individuals who have a chronic condition and who may not be taking care of all aspects of the condition such as diabetes and the need for periodontal treatment and maintenance. Combining the insurance programs also simplifies the process for employees and their dependents. Employees and covered dependents will have one Cigna card to use for medical, dental, or vision care and they will have the ability to take care of all of their insurance questions by calling just one telephone number or signing on to only one website.

Cigna also provides, at no additional cost, an integrated online enrollment and administration system that will assist the Human Resources Department in better maintenance of enrollment data. This system, called Choicelinx, will also serve as an online user friendly self-service resource for employees and dependents. Employees will have the ability to learn about offered plans, assist with estimating how much money to put in their FSA, enroll in the City's various insurance plans, make qualifying event changes, change beneficiary information and receive a breakdown of biweekly payroll deductions based on their choices. Cigna also offers employees phone apps that will provide easy access to benefits related questions.

The cost breakdown of the proposal is as follows:

	<u>4 Year Amount</u>	<u>Line Item</u>
Medical Administrative Fees*:	\$1,994,622	62107.510300
Dental Administrative Fees**:	\$186,371	62120.510300
Individual Stop Loss Insurance:	\$3,215,304	62107.555700
Aggregate Stop Loss Insurance:	\$257,040	62107.555750
Total Four Year Contract:	\$5,653,337	

- *Includes FSA and COBRA administrative fees and \$200,000 transitional credit.
- **Includes \$20,000 transitional credit.
- The Wellness Credit of \$400,000 (\$100,000 per year) will be credited throughout the respective plan years as Wellness related activities are planned and executed.

REQUESTED ACTION:

Please review and approve this recommendation of award to Cigna.

Attachments:

1. Financial Comparison (Aon Benefits Consulting)
 - Medical / Rx ASO Financial Comparison
 - Dental ASO Benefit and Total Cost Comparison
 - Voluntary Vision Benefit and Financial Comparison
 - FSA – RFP Response
 - COBRA – RFP Response
2. Administrative Services Only Agreement – Cigna
 - Medical
 - Dental
 - FSA
 - COBRA
3. Choicelinx License and Services Agreement
4. Cigna Stop Loss Policy

(ASO) Medical / Rx Financial Comparison- Effective July 1, 2015

	Enrolled	A			B			C			D			E			F			G			H			I			J			K			L			M			N			O		
		Enrolled	Choice Plus 001 Premium Plan	Enrolled	United Healthcare	Choice Plus 067 Core Plan	Enrolled	HRA Choice Plus 024 Value Plan (HRA)	Choice Plus 001 Premium Plan	Enrolled	United Healthcare	Choice Plus 067 Core Plan	Enrolled	HRA Choice Plus 024 Value Plan (HRA)	Open Access Plus Premier Plan	Enrolled	Cigna	Open Access Plus Core Plan	Enrolled	Choice Fund HRA Open Access Plus	PPO \$0 Ded \$2,500 OOP	Enrolled	Presbyterian	PPO \$100 Ded \$1,000 OOP Max	Enrolled	PPO \$1,500 \$3,000 OOP Max	Premium Plan	Enrolled	Blue Cross Blue Shield	Core Plan	Enrolled	Value Plan														
Contract Type		Current						Renewal						Quote 1						Quote 2						Quote 3																				
		Paid / 12						Paid / 12						24 / 12						15 / 12						(Admin) Quoted \$44.15 on an Immature Basis (ISL and ASL) 15 / 12																				
ADMINISTRATION								\$50,000 Wellness Budget						\$100,000 Wellness Budget \$200,000 Transitional Relief Credit						Includes One Month Credit						Aon's Estimated Mature Admin																				
	PSPM 1,186	\$38.76	53	\$38.76	21	\$43.39	\$34.81	\$34.81	\$39.44	\$33.88	\$33.88	\$38.82	\$39.21	\$39.21	\$39.21	\$45.90	\$45.90	\$45.90																												
Total		\$551,632		\$24,651		\$10,934	\$495,416	\$22,139	\$9,939	\$482,180	\$21,548	\$9,783	\$558,037	\$24,938	\$9,881	\$653,249	\$29,192	\$11,567																												
Combined Annual		\$587,218						\$527,494						\$513,510						\$592,855						\$694,008																				
\$ Difference from Current								-\$59,724						-\$53,707						-\$5,637						\$106,790																				
% Difference from Current								-10.2%						-12.6%						1.0%						18.2%																				
\$ Difference from Renewal														-\$13,983						\$65,361						\$166,514																				
SPECIFIC STOP LOSS		\$250,000 (does not include Rx)						\$250,000 (does not include Rx)						\$250,000 (Includes Rx)						\$250,000 (Includes Rx)						\$250,000 (Includes Rx)																				
	PSPM 1,186	\$56.23	53	\$56.23	21	\$56.23	\$56.23	\$56.23	\$56.23	\$53.15	\$53.52	\$53.00	\$52.79	\$52.79	\$52.79	\$47.47	\$47.47	\$47.47																												
Total		\$800,265		\$35,762		\$14,170	\$800,265	\$35,762	\$14,170	\$756,431	\$34,039	\$13,356	\$751,307	\$33,574	\$13,303	\$675,593	\$30,191	\$11,962																												
Combined Annual		\$850,198						\$850,198						\$803,826						\$798,185						\$717,746																				
\$ Difference from Current								\$0						-\$46,372						-\$132,413						-\$132,451																				
% Difference from Current								0.0%						-5.5%						-6.1%						-15.6%																				
\$ Difference from Renewal														-\$46,372						-\$52,013						-\$132,451																				
AGGREGATE STOP LOSS		125%						125%						125%						125%						125%																				
	PSPM 1,186	\$4.40	53	\$4.40	21	\$4.40	\$4.40	\$4.40	\$4.40	\$4.25	\$4.25	\$4.25	\$3.41	\$3.41	\$3.41	\$0.87	\$0.87	\$0.87																												
Total		\$62,621		\$2,798		\$1,109	\$62,621	\$2,798	\$1,109	\$60,486	\$2,703	\$1,071	\$48,531	\$2,169	\$859	\$12,382	\$553	\$219																												
Combined Annual		\$66,528						\$66,528						\$64,260						\$51,559						\$13,154																				
\$ Difference from Current								\$0						-\$2,268						-\$14,969						-\$53,374																				
% Difference from Current								0.0%						-3.4%						-22.5%						-80.2%																				
\$ Difference from Renewal														-\$2,268						-\$14,969						-\$53,374																				
TOTAL FIXED COSTS																																														
Combined Annual		\$1,503,944						\$1,444,220						\$1,381,596						\$1,556,192						\$1,538,502																				
\$ Difference from Current								-\$59,724						-\$122,348						\$52,249						\$34,558																				
% Difference from Current								-4.0%						-8.1%						3.5%						2.3%																				
\$ Difference from Renewal														-\$62,624						\$111,973						\$94,282																				
Additional Items																				One Month Admin Credit for Transition Relief (approx. \$49,400)																										
Transitional Relief Credit																				-\$49,400						\$0																				
Run-out Administration																				\$146,504						\$146,504																				
TOTAL FIXED COSTS - YEAR ONE																																														
Combined Annual		\$1,503,944						\$1,444,220						\$1,328,100						\$1,653,296						\$1,685,006																				
\$ Difference from Current								-\$59,724						-\$175,844						\$149,353						\$181,062																				
% Difference from Current								-4.0%						-11.7%						9.0%						12.0%																				
\$ Difference from Renewal														-\$116,120						\$209,077						\$240,786																				

UHC Run-out Administration (12 months) - \$38.84 per enrolled employee for three months (approx. \$146,504 based on an average of 1,257 enrolled employees)

(ASO) Dental Benefit and Total Cost Comparison - Effective July 1, 2015

LEGEND		A		B		C		D		E		F		G		H		I		J		K		L		M		N		O	
Enhancement		United Concordia Concordia Flex Plan		United Concordia Concordia Flex Plan		United Concordia Concordia Flex Plan		Delta Dental Plan of NM Delta Dental PPO Point-of-Service		Delta Dental Plan of NM Delta Dental PPO Point-of-Service		MetLife		MetLife		Blue Cross Blue Shield Blue Care Freedom Dental		Blue Cross Blue Shield Blue Care Freedom Dental		United Health Care Passive PPO CSO		United Health Care Passive PPO CSO		Cigna Cigna Total DPPO		Cigna Cigna Total DPPO		Cigna Cigna Total DPPO			
Difference		Current		RFP Response		RFP Response		Quote 1		Quote 1		Quote 2		Quote 2		Quote 3		Quote 3		Quote 4		Quote 4		Quote 5		Quote 5		Quote 5			
Reduction		In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network Delta Dental PPO Provider	Delta Dental Premier Dentist	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network			
Benefit Details		1,300 Participating		1,300 Participating		1,300 Participating		80% of Eligible Employees		Out of Network	88% of Eligible Employees		75% of Eligible Employees		75% of Eligible Employees		75% of Eligible Employees		65% of Eligible Employees												
Participation Requirements		Alliance Allowance		99th Percentile		Alliance Allowance		99th Percentile		PPO Fee Schedule	Premier Maximum Approved Fees	PPO Fee Schedule (balance billing may apply)	Fee Schedule	99th Percentile	Fee Schedule	90th Percentile	Fee Schedule	95th Percentile	Fee Schedule	95th Percentile	Fee Schedule	95th Percentile	Fee Schedule	95th Percentile	Fee Schedule	95th Percentile	Fee Schedule	95th Percentile	Fee Schedule	95th Percentile	
Reimbursement Levels		None		None		None		None		None		None		None		None		None		None		None		None		None		None			
Waiting Period(s) / Late Entrant Provisions		Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes			
Annual Open Enrollment		\$50		\$50		\$50		\$50		\$50		\$50		\$50		\$50		\$50		\$50		\$50		\$50		\$50		\$50			
Deductible		\$150		\$150		\$150		\$150		\$150		\$150		\$150		\$150		\$150		\$150		\$150		\$150		\$150		\$150			
Individual		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500			
Family		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500			
Calendar Year Maximums		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500			
Calendar Year		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500			
Implants		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500		\$1,500			
Lifetime Orthodontia																															
Services		Plan pays 100% (deductible waived)		Plan pays 100% (deductible waived)		Plan pays 100% (deductible waived)		Plan pays 100% (deductible waived)		Plan pays 100% (deductible waived)		Plan pays 100% (deductible waived)		Plan pays 100% (deductible waived)		Plan pays 100% (deductible waived)		Plan pays 100% (deductible waived)		Plan pays 100% (deductible waived)		Plan pays 100% (deductible waived)		Plan pays 100% (deductible waived)		Plan pays 100% (deductible waived)		Plan pays 100% (deductible waived)			
Diagnostic / Preventive		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%			
Restorative Services		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%			
Anesthesia (General / I.V.)		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%			
Oral Surgery		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%			
Endodontics (Root Canal/Pulp Therapy)		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%			
Periodontics		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%		Ded + 20%			
Implants		Ded + 50%		Ded + 50%		Ded + 50%		Ded + 50%		Ded + 50%		Ded + 50%		Ded + 50%		Ded + 50%		Ded + 50%		Ded + 50%		Ded + 50%		Ded + 50%		Ded + 50%		Ded + 50%			
Crowns/Bridges		Ded + 50%		Ded + 50%		Ded + 50%		Ded + 50%		Ded + 50%		Ded + 50%		Ded + 50%		Ded + 50%		Ded + 50%		Ded + 50%		Ded + 50%		Ded + 50%		Ded + 50%		Ded + 50%			
Orthodontia		50% (no age limit) (deductible waived)		50% (no age limit) (deductible waived)		50% (no age limit) (deductible waived)		50% (no age limit) (deductible waived)		50% (no age limit) (deductible waived)		50% (no age limit) (deductible waived)		50% (no age limit) (deductible waived)		50% (no age limit) (deductible waived)		50% (no age limit) (deductible waived)		50% (no age limit) (deductible waived)		50% (no age limit) (deductible waived)		50% (no age limit) (deductible waived)		50% (no age limit) (deductible waived)		50% (no age limit) (deductible waived)			
Orthodontic Services																															
ASO Fee				2 Year Fee Guarantee with 3rd Year Renewal Cap (not to exceed \$0.10)				\$3.63 = 1 Year Rate Guarantee \$3.70 = 2nd Year (+3.5% over Year 1) \$3.83 = 4th Year (+3.5% over Year 2)				3 Year Rate Guarantee				2 Year Fee Guarantee				2 Year Fee Guarantee				2 Year Fee Guarantee Includes \$20,000 Transitional Relief Credit							
PEPM	1,240	\$3.60		\$3.50		\$3.50		\$3.70		\$3.99		\$3.24		\$3.58		\$3.45															
Estimated Monthly Premium		\$4,464		\$4,340		\$4,340		\$4,588		\$4,948		\$4,018		\$4,439		\$4,278															
Estimated Annual Premium		\$53,568		\$52,080		\$52,080		\$55,056		\$59,371		\$48,211		\$53,270		\$51,336															
\$ Difference from Current				-\$1,488		-\$1,488		\$1,488		\$5,803		-\$5,357		-\$298		-\$2,232															
% Difference from Current				-2.8%		-2.8%		2.8%		10.8%		-10.0%		-0.6%		-4.2%															
\$ Difference from Renewal								\$2,976		\$7,291		-\$3,869		\$1,190		-\$744															
Additional Items																															
Transitional Relief Credit		N/A		N/A		N/A		\$0		\$0		\$0		\$0		\$0										-\$20,000					
Run-out Administration		N/A		N/A		N/A		\$8,928		\$8,928		\$8,928		\$8,928		\$8,928															
ASO Fee - Year One																															
Estimated Annual Premium		\$53,568		\$52,080		\$52,080		\$63,984		\$68,299		\$57,139		\$62,198		\$40,264															
\$ Difference from Current				-\$1,488		-\$1,488		\$10,416		\$14,731		\$3,571		\$8,630		-\$13,304															
% Difference from Current				-2.8%		-2.8%		19.4%		27.5%		6.7%		16.1%		-24.8%															
\$ Difference from Renewal								\$11,904		\$16,219		\$5,059		\$10,118		-\$11,816															

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United Concordia Run-out Administration (12 months) - \$3.70 per enrolled employee for two months (approx. \$9,000 based on 1,240 enrolled employees)

Voluntary Vision Benefit and Financial Comparison - Effective July 1, 2015

		A		B		C		D		E		F		G		H		I		J		K		L		M		N		O		P	
		United Health Care		United Health Care		United Health Care		Cigna		Cigna		Davis Vision (BCBSNM)		Davis Vision (BCBSNM)		Davis Vision (BCBSNM)		Superior Vision (Presbyterian)		Superior Vision (Presbyterian)		Vision Service Plan											
		V1005		V1005		V1005		PPO (C1)		PPO (C1)		Quote 2		Quote 3		Quote 4		Quote 5		Quote 6		Platinum 130 Plan		VSP Choice Plan		VSP Choice Plan		VSP Choice Plan		VSP Choice Plan			
		Current		RFP Response		Quote 1		Quote 2		Quote 3		Quote 4		Quote 5		Quote 6																	
		100% Employee Paid		100% Employee Paid		100% Employee Paid		100% Employee Paid		100% Employee Paid		100% Employee Paid		100% Employee Paid		75% with a minimum of 5 EE's enrolled if City pays greater than 50% of the premium		100% Employee Paid		Packaged with Medical													
		No Participation Requirement		No Participation Requirement		20%		1 Enrolled		Bundled with Medical								No Participation Requirement															
Benefit Frequency		In Network		Out of Network		In Network		Out of Network		In Network		Out of Network		In Network		Out of Network		In Network		Out of Network		In Network		Out of Network		In Network		Out of Network		In Network		Out of Network	
Exam		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months	
Lenses		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months	
Frames		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months		12 months	
Benefits																																	
Examination		\$10 copay	up to \$40	\$10 copay	up to \$40	\$10 copay	up to \$45	\$10 copay	up to \$40	\$10 copay	up to \$40	\$10 copay	up to \$40	\$10 copay	up to \$40	\$10 copay	up to \$35	\$10 copay	up to \$45	\$10 copay	up to \$45	\$10 copay	up to \$45	\$10 copay	up to \$45	\$10 copay	up to \$45	\$10 copay	up to \$45	\$10 copay	up to \$45		
Single Vision Lenses		\$10 copay	up to \$40	\$10 copay	up to \$40	\$10 copay	up to \$32	\$10 copay	up to \$40	\$10 copay	up to \$40	\$10 copay	up to \$40	\$10 copay	up to \$40	\$10 copay	up to \$25	\$10 copay	up to \$30	\$10 copay	up to \$30	\$10 copay	up to \$30	\$10 copay	up to \$30	\$10 copay	up to \$30	\$10 copay	up to \$30	\$10 copay	up to \$30		
Bifocal Lenses		\$10 copay	up to \$60	\$10 copay	up to \$60	\$10 copay	up to \$55	\$10 copay	up to \$60	\$10 copay	up to \$60	\$10 copay	up to \$60	\$10 copay	up to \$60	\$10 copay	up to \$40	\$10 copay	up to \$50	\$10 copay	up to \$50	\$10 copay	up to \$50	\$10 copay	up to \$50	\$10 copay	up to \$50	\$10 copay	up to \$50	\$10 copay	up to \$50		
Trifocal Lenses		\$10 copay	up to \$80	\$10 copay	up to \$80	\$10 copay	up to \$65	\$10 copay	up to \$80	\$10 copay	up to \$80	\$10 copay	up to \$80	\$10 copay	up to \$80	\$10 copay	up to \$45	\$10 copay	up to \$65	\$10 copay	up to \$65	\$10 copay	up to \$65	\$10 copay	up to \$65	\$10 copay	up to \$65	\$10 copay	up to \$65	\$10 copay	up to \$65		
Frames		\$10 copay (up to \$130 allowance; 30% discount on overage)	up to \$45	\$10 copay (up to \$130 allowance; 30% discount on overage)	up to \$45	\$10 copay (up to \$130 allowance; 20% discount on overage)	up to \$71	(Premier Level) \$25 copay up to \$195 (Fashion/Designer Level) No Copay up to \$195 allowance (Non-Collection) up to \$105 Retail; plus a 20% discount on any overage	up to \$45	(Premier Level) \$25 copay (Fashion/Designer Level) Included (Non-Collection) up to \$105 Retail; plus a 20% discount on any overage	up to \$45	\$10 copay (\$130 Allowance)	up to \$70	\$10 copay (\$130 Allowance)	up to \$70	\$10 copay (\$130 Allowance)	up to \$70	\$10 copay (\$130 Allowance)	up to \$70	\$10 copay (\$130 Allowance)	up to \$70	\$10 copay (\$130 Allowance)	up to \$70	\$10 copay (\$130 Allowance)	up to \$70	\$10 copay (\$130 Allowance)	up to \$70	\$10 copay (\$130 Allowance)	up to \$70	\$10 copay (\$130 Allowance)	up to \$70		
Contact Lens (Fitting and Evaluation)		(Covered in Full Selection) \$10 copay up to 4 boxes (Non-Selection Contacts) No Copay (up to \$105 allowance)	(Covered in Full Selection) up to \$105 (Non-Selection Contacts) up to \$105	(Covered in Full Selection) \$10 copay up to 4 boxes (Non-Selection Contacts) No Copay (up to \$105 allowance)	(Covered in Full Selection) up to \$105 (Non-Selection Contacts) up to \$105	No Copay (up to \$130 allowance)	up to \$105	(Collection Contact Lenses) \$10 copay Disposable up to 4 boxes/multi-packs Planned Replacement up to 2 boxes/multi-packs (Non-Selection Contacts) up to \$105 allowance plus 15% discount on any overage	up to \$105	(Collection Contact Lenses) \$10 copay Disposable up to 4 boxes/multi-packs Planned Replacement up to 2 boxes/multi-packs (Non-Selection Contacts) up to \$105 allowance plus 15% discount on any overage	up to \$105	\$10 copay (\$105 Allowance)	up to \$80	\$10 copay (\$105 Allowance)	up to \$80	\$10 copay (\$105 Allowance)	up to \$80	\$10 copay (\$105 Allowance)	up to \$80	\$10 copay (\$105 Allowance)	up to \$80	\$10 copay (\$105 Allowance)	up to \$80	\$10 copay (\$105 Allowance)	up to \$80	\$10 copay (\$105 Allowance)	up to \$80	\$10 copay (\$105 Allowance)	up to \$80	\$10 copay (\$105 Allowance)	up to \$80		
Contacts (Elective)						No Copay (up to \$130 allowance)	up to \$105	(Collection Contact Lenses) \$10 copay Disposable up to 4 boxes/multi-packs Planned Replacement up to 2 boxes/multi-packs (Non-Selection Contacts) up to \$105 allowance plus 15% discount on any overage	up to \$105	(Collection Contact Lenses) \$10 copay Disposable up to 4 boxes/multi-packs Planned Replacement up to 2 boxes/multi-packs (Non-Selection Contacts) up to \$105 allowance plus 15% discount on any overage	up to \$105	\$10 copay (\$105 Allowance)	up to \$80	\$10 copay (\$105 Allowance)	up to \$80	\$10 copay (\$105 Allowance)	up to \$80	\$10 copay (\$105 Allowance)	up to \$80	\$10 copay (\$105 Allowance)	up to \$80	\$10 copay (\$105 Allowance)	up to \$80	\$10 copay (\$105 Allowance)	up to \$80	\$10 copay (\$105 Allowance)	up to \$80	\$10 copay (\$105 Allowance)	up to \$80	\$10 copay (\$105 Allowance)	up to \$80		
LASIK		Discount is available	Not Covered	Discount is available	Not Covered	Discount is available	Not Covered	Discount is available	Not Covered	Discount is available	Not Covered	Discount is available	Not Covered	Discount is available	Not Covered	Discount is available	Not Covered	Discount is available	Not Covered	Discount is available	Not Covered	Discount is available	Not Covered	Discount is available	Not Covered	Discount is available	Not Covered	Discount is available	Not Covered	Discount is available	Not Covered		
Rates		Guaranteed through June 30, 2015		3 Year		2 Year		4 Year		4 Year		3 Year																					
Employee Only		147	\$7.72	\$7.72	\$7.44	\$6.88	\$3.66	\$6.68																									
Employee + Spouse		106	\$15.66	\$15.66	\$14.87	\$13.95	\$7.43	\$11.37																									
Employee + Child(ren)		89	\$16.40	\$16.40	\$15.02	\$14.61	\$7.79	\$12.05																									
Family		179	\$20.76	\$20.76	\$23.97	\$18.49	\$9.85	\$18.06																									
Enrollment Total		521																															
Estimated Monthly Premium			\$7,970	\$7,970	\$8,297	\$7,100	\$3,782	\$6,492																									
Estimated Annual Premium			\$95,645	\$95,645	\$99,567.72	\$85,201	\$45,385	\$77,908																									
\$ Difference from Current			\$0.00	\$3,922	-\$10,445	-\$50,261	-\$17,737																										
% Difference from Current			0.0%	4.1%	-10.9%	-52.5%	-18.5%																										
\$ Difference from Renewal				\$3,922	-\$10,445	-\$50,261	-\$17,737																										
ASO Fee																																	
Rate Guarantee																																	
Employee Only		521																															
Estimated Monthly Premium																																	
Estimated Annual Premium																																	
% Commission Included			Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission		

DISCLAIMER: The financial and benefit information outlined in this summary has been prepared for you to use as an "at-a-glance" reference. It is intended for summary purposes only. In all cases only the official plan documents control the administration and operation of the plans.

Life / AD&D and Dependent Life Benefit and Financial Comparison - Effective July 1, 2015

	Enhancement					
	Harvest					
	A	B	C	D	E	F
	Cigna	Cigna	Standard Insurance	MetLife	Minnesota Life	Dearborn National
	Current	RFP Response	Quote 2	Quote 3	Quote 4	Quote 5
1 Plan Details						
2 Participation Requirement	100%	100%	100%	100%	100%	100%
3 Grandfather Existing Participants	Incumbent Carrier	Incumbent Carrier	Yes	Yes	Yes	Yes
4 Life Class Description						
5 (Class 1) All active full-time and part-time EE's working a minimum of 20 hours per week and who are enrolled in the employer sponsored Medical plan, excluding EE's classified as Undercover Agents	\$10,000	\$10,000	\$10,000	\$10,000	\$10,000	\$10,000
6 (Class 2) All active full-time and part-time Undercover Agents regularly working a minimum of 20 hours per week	\$250,000	\$250,000	\$250,000	\$250,000	\$250,000	\$250,000
7 AD&D Class Description						
8 (Class 1) All active full-time and part-time EE's working a minimum of 20 hours per week and who are enrolled in the employer sponsored Medical plan, excluding EE's classified as Undercover Agents	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000
9 (Class 2) All active full-time and part-time Undercover Agents regularly working a minimum of 20 hours per week	\$250,000	\$250,000	\$250,000	\$250,000	\$250,000	\$250,000
10 Guarantee Issue	GI is separate from Supp Life	GI is separate from Supp Life	GI is separate from Supp Life	GI is separate from Supp Life	GI is separate from Supp Life	GI is separate from Supp Life
11 (Class 1) All active full-time and part-time EE's working a minimum of 20 hours per week and who are enrolled in the employer sponsored Medical plan, excluding EE's classified as Undercover Agents	\$10,000	\$10,000	\$10,000	\$10,000	\$10,000	\$10,000
12 (Class 2) All active full-time and part-time Undercover Agents regularly working a minimum of 20 hours per week	\$250,000	\$250,000	\$250,000	\$250,000	\$250,000	\$250,000
13 Benefit Details						
14 Age Reduction Schedule	Age 70 reduces to 65% Age 75 reduces to 45%	Age 70 reduces to 65% Age 75 reduces to 45%	Age 70 reduces to 65% Age 75 reduces to 45%	Age 70 reduces to 65% Age 75 reduces to 45%	Age 70 reduces to 65% Age 75 reduces to 45%	Age 70 reduces to 65% Age 75 reduces to 45%
15 Portability	(Class 1) EE and Dependents (Class 2) EE Only	(Class 1) EE and Dependents (Class 2) EE Only	Included	Included	Included	Included
16 Conversion Privilege	Included	Included	Included	Included	Included	Included
17 Settlement Option	Included	Included	Included	Included	Included	Included
18 Accelerated Death Benefit Percentage	Lesser of 50% up to \$50,000 for Basic Benefits	Lesser of 50% up to \$50,000 for Basic Benefits	75% to \$250,000	80% up to \$500,000	100% to \$1,000,000 Maximum	75% to \$250,000
19 Accelerated Death Maximum Independent of VTGL or Combined	Combined	Combined	Combined	Separate	Combined	Combined
20 Waiver of Premium						
21 Included?	Included (6 Month Total Disability Waiting Period)	Included (6 Month Total Disability Waiting Period)	Included	Included (6 Month Total Disability Waiting Period)	Included (6 Month Total Disability Waiting Period)	Included (6 Month Total Disability Waiting Period)
22 Age requirement prior to Disability	age 60	age 60	age 60	age 60	age 60	age 60
23 Duration	waived for the duration of disability	waived for the duration of disability	No Termination as long as totally disabled	to age 70	to age 70	SSNRA
24 Rates						
25 Number of Eligible Lives	1,250	1,250				
26 Rate Guarantee	through June 30, 2015	3 Year	3 Year	3 Year	3 Year	3 Year
27 Life / \$1,000	\$0.067	\$0.072	\$0.059	\$0.123	\$0.175	\$0.156
28 AD&D / \$1,000	\$0.022	\$0.022	\$0.018	\$0.022	\$0.026	\$0.022
29 Combined Life / AD&D Rate	\$0.089	\$0.094	\$0.077	\$0.145	\$0.201	\$0.178
30 Volume (Current)	\$13,227,000	\$13,227,000	\$13,227,000	\$13,227,000	\$13,227,000	\$13,227,000
31 Estimate Total Annual Premium	\$14,126	\$14,920	\$12,222	\$23,015	\$31,904	\$28,253
32 \$ Difference from Current		\$794	-\$1,905	\$8,889	\$17,777	\$14,126
33 % Difference from Current		5.6%	-13.5%	62.9%	125.8%	100.0%
34 Additional Items						
35 Transitional Relief Credit	N/A	-\$8,000	\$0	\$0	\$0	\$0
36 Estimate Total Annual Premium - Year One	\$14,126	\$6,920	\$12,222	\$23,015	\$31,904	\$28,253
37 \$ Difference from Current		-\$7,206	-\$1,905	\$8,889	\$17,777	\$14,126
38 % Difference from Current		-51.0%	-13.5%	62.9%	125.8%	100.0%
39 Dependent Life						
40 Dependent Life Rate	\$0.65 per Unit	\$0.702 per Unit	\$0.65 per Unit	\$0.86 per \$5,000	\$1.63 per Unit	\$1.51 per Unit
41 Spouse Benefit	(EE Class 1 or Class 2) \$5,000	(EE Class 1 or Class 2) \$5,000	(EE Class 1 or Class 2) \$5,000	(EE Class 1 or Class 2) \$5,000	(EE Class 1 or Class 2) \$5,000	(EE Class 1 or Class 2) \$5,000
42 Child(ren) Benefit	(EE Class 1 or Class 2) \$5,000 Birth - age 26	(EE Class 1 or Class 2) \$5,000 Birth - age 26	(EE Class 1 or Class 2) \$5,000 Birth - age 25	(EE Class 1 or Class 2) \$5,000 Birth - age 23	(EE Class 1 or Class 2) \$5,000 Birth - age 26	(EE Class 1 or Class 2) \$1,000 Birth - 6 Months \$5,000 Birth - age 26
43 % Commission Included	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission	Net of Commission
44 National Additional Commission Disclosure	In addition to the commission enumerated above, Aon may earn additional compensation of .5% to 4% paid by one or more of the vendors identified as part of Aon's National Additional Commission Program. If the Vendor(s) you ultimately choose to provide coverage has a National Additional Commission agreement with Aon, disclosure will be included in our Comprehensive Disclosure Statement (CDS), prior to the time we seek your consent to bind your insurance program.					
45 National Additional Commission Included	N/A	N/A	N/A	up to 7%	N/A	N/A
46 DISCLAIMER: The financial and benefit information outlined in this summary has been prepared for you to use as an "at-a-glance" reference. It is intended for summary purposes only. In all cases only the official plan documents control the administration and operation of the plans.						

Supplemental Life / AD&D Benefit and Rate Illustration - Effective July 1, 2015

	A		B		C		D		E		F		G		H		I		J		K		L		M		N																			
Enhancement																																														
Difference																																														
	Cigna				Cigna				Cigna				Standard				MetLife				Minnesota Life				Dearborn National																					
	Current		RFP Response		Quote 1		Quote 2		Quote 3		Quote 4		Quote 5																																	
1 Plan Details																																														
2 Participation Requirement	20% of Eligible		20% of Eligible		20% of Eligible		20% of Eligible		79% of Eligible		75% of Eligible		No Participation Requirement		79% of Eligible																															
3 Rate Guarantee	through June 30, 2015		2 Year		3 Year		3 Year		3 Year		3 Year		3 Year		3 Year																															
4 One Time Open Enrollment Period	N/A		No		Included		Included		Included		No		Included		No																															
5 Benefit Amount																																														
6 Employee (All active, full-time and part-time EE's regularly working a minimum of 20 hours per week)	2 - 5 X BAE not to exceed \$500,000		2 - 5 X BAE not to exceed \$500,000		2 - 5 X BAE not to exceed \$500,000		2 - 5 X BAE not to exceed \$500,000		2 - 5 X BAE not to exceed \$500,000		2 X - 5 X BAE to the lesser of 5 X pay or \$500,000		2 X - 5 X BAE to \$500,000		2 X - 5 X BAE in increments of 1 X salary to \$500,000																															
7 Spouse	50% of EE benefit not to exceed \$250,000		50% of EE benefit not to exceed \$250,000		50% of EE benefit not to exceed \$250,000		50% of EE benefit not to exceed \$250,000		50% of EE benefit not to exceed \$250,000		50% of EE benefit to a maximum of \$250,000; not to exceed 50% of EE life amount		50% of EE benefit to \$250,000		\$5,000 increments to \$50,000																															
8 Domestic Partner Coverage	Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes																															
9 Child(ren)	\$2,000 Birth - 6 months \$2,000 increments to \$10,000 6 months - 26 years		\$2,000 Birth - 6 months \$2,000 increments to \$10,000 6 months - 26 years		\$2,000 Birth - 6 months \$2,000 increments to \$10,000 6 months - 26 years		\$2,000 Birth - 6 months \$2,000 increments to \$10,000 6 months - 26 years		\$2,000 Birth - 6 months \$2,000 increments to \$10,000 6 months - 26 years		\$2,000 under 15 days \$2,000 15 days - less than 12 months \$2,000 increments to \$10,000 - 12 months to age 26		\$2,000 increments to \$10,000 - Live Birth to age 26		\$1,000 Birth - 6 months \$2,000 increments to \$10,000 6 months - age 26																															
10 Guarantee Issue																																														
11 Employee	\$365,000		\$365,000		\$365,000		\$365,000		\$365,000		lesser of \$365,000 and 5 X BAE		\$365,000		\$365,000																															
12 Spouse	\$50,000		\$50,000		\$50,000		\$50,000		\$50,000		\$50,000		\$50,000		\$50,000																															
13 Child(ren)	All Amounts		All Amounts		All Amounts		All Amounts		All Amounts		All Amounts		All Amounts		All Amounts																															
14 Reduction Schedule																																														
15 Employee	Age 70 reduces to 65% Age 75 reduces to 45%		Age 70 reduces to 65% Age 75 reduces to 45%		Age 70 reduces to 65% Age 75 reduces to 45%		Age 70 reduces to 65% Age 75 reduces to 45%		Age 70 reduces to 65% Age 75 reduces to 45%		Age 70 reduces to 65% Age 75 reduces to 45%		No Age Reductions		Age 70 reduces to 65% Age 75 reduces to 45%		Age 70 reduces to 65% Age 75 reduces to 45%																													
16 Spouse	Age 70 reduces to 65% Age 75 reduces to 45%		Age 70 reduces to 65% Age 75 reduces to 45%		Age 70 reduces to 65% Age 75 reduces to 45%		Age 70 reduces to 65% Age 75 reduces to 45%		Age 70 reduces to 65% Age 75 reduces to 45%		Age 70 reduces to 65% Age 75 reduces to 45%		No Age Reductions		Age 70 reduces to 65% Age 75 reduces to 45%		Age 70 reduces to 65% Age 75 reduces to 45%																													
17 Benefit Details																																														
18 Waiver of Premium	Included (6 Month Total Disability Waiting Period)		Included (6 Month Total Disability Waiting Period)		Included (6 Month Total Disability Waiting Period)		Included (6 Month Total Disability Waiting Period)		Included (6 Month Total Disability Waiting Period)		Included (6 Month Total Disability Waiting Period)		Included (6 Month Total Disability Waiting Period)		Included (6 Month Total Disability Waiting Period)		Included (6 Month Total Disability Waiting Period)																													
19 Portability - Employee and Dependent	Both - Employee and Dependent		Both - Employee and Dependent		Both - Employee and Dependent		Both - Employee and Dependent		Both - Employee and Dependent		Both - Employee and Dependent		Both - Employee and Dependent		Both - Employee and Dependent		Both - Employee and Dependent																													
20 Conversion - Employee and Dependent	Both - Employee and Dependent		Both - Employee and Dependent		Both - Employee and Dependent		Both - Employee and Dependent		Both - Employee and Dependent		Both - Employee and Dependent		Both - Employee and Dependent		Both - Employee and Dependent		Both - Employee and Dependent																													
21 Accelerated Death Benefit	50% to \$50,000		50% to \$50,000		50% to \$50,000		50% to \$50,000		75% to \$500,000		80% to \$500,000		100% to \$1,000,000 Maximum		75% to \$250,000																															
22 Do Rates Straddle IRS Table	Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes																													
23 Voluntary Life Rate per \$1,000	Employee Spouse		Employee Spouse		Employee Spouse		Employee Spouse		Employee Spouse		Employee Spouse		Employee Spouse		Employee Spouse		Employee Spouse																													
24 < 25	\$0.193	\$0.050	\$0.193	\$0.050	\$0.212	\$0.055	\$0.183	\$0.050	\$0.195	\$0.057	\$0.209	\$0.068	\$0.193	\$0.116																																
25 25 - 29	\$0.193	\$0.057	\$0.193	\$0.057	\$0.212	\$0.063	\$0.183	\$0.057	\$0.195	\$0.057	\$0.209	\$0.078	\$0.193	\$0.132																																
26 30 - 34	\$0.193	\$0.064	\$0.193	\$0.064	\$0.212	\$0.071	\$0.183	\$0.064	\$0.195	\$0.064	\$0.209	\$0.088	\$0.193	\$0.148																																
27 35 - 39	\$0.193	\$0.071	\$0.193	\$0.071	\$0.212	\$0.078	\$0.183	\$0.071	\$0.195	\$0.071	\$0.209	\$0.097	\$0.193	\$0.164																																
28 40 - 44	\$0.193	\$0.086	\$0.193	\$0.086	\$0.212	\$0.095	\$0.183	\$0.086	\$0.195	\$0.086	\$0.209	\$0.118	\$0.193	\$0.199																																
29 45 - 49	\$0.193	\$0.150	\$0.193	\$0.150	\$0.212	\$0.165	\$0.183	\$0.150	\$0.195	\$0.150	\$0.209	\$0.205	\$0.193	\$0.347																																
30 50 - 54	\$0.193	\$0.222	\$0.193	\$0.222	\$0.212	\$0.245	\$0.183	\$0.222	\$0.195	\$0.222	\$0.209	\$0.304	\$0.193	\$0.513																																
31 55 - 59	\$0.193	\$0.429	\$0.193	\$0.429	\$0.212	\$0.473	\$0.183	\$0.429	\$0.195	\$0.429	\$0.209	\$0.587	\$0.193	\$0.991																																
32 60 - 64	\$0.193	\$0.586	\$0.193	\$0.586	\$0.212	\$0.646	\$0.183	\$0.586	\$0.195	\$0.586	\$0.209	\$0.802	\$0.193	\$1.354																																
33 65 - 69	\$0.193	\$0.980	\$0.193	\$0.980	\$0.212	\$1.081	\$0.183	\$0.980	\$0.195	\$0.980	\$0.209	\$1.342	\$0.193	\$2.264																																
34 70 - 74	\$0.193	\$1.845	\$0.193	\$1.845	\$0.212	\$2.035	\$0.183	\$1.845	\$0.195	\$1.845	\$0.209	\$2.526	\$0.193	\$4.262																																
35 75+	\$0.193	\$3.439	\$0.193	\$3.439	\$0.212	\$3.793	\$0.183	\$3.439	\$0.195	\$1.845	\$0.209	\$4.709	\$0.193	\$7.944																																
36 Dependent Child(ren) Rate	\$0.12 per \$1,000		\$0.12 per \$1,000		\$0.132 per \$1,000		\$0.09 per \$1,000		\$0.171 per \$1,000		\$0.12 per \$1,000		\$0.277 per \$1,000																																	
37 Voluntary AD&D																																														
38 Employee Only	\$0.025 per \$1,000		\$0.025 per \$1,000		\$0.025 per \$1,000		\$0.023 per \$1,000		\$0.027 per \$1,000		\$0.026 per \$1,000		\$0.025 per \$1,000																																	
39 Family	\$0.037 per \$1,000		\$0.037 per \$1,000		\$0.037 per \$1,000		\$0.035 per \$1,000		\$0.036 per \$1,000		\$0.047 per \$1,000		\$0.037 per \$1,000																																	
40 % Commission Included	Net of Commission		Net of Commission		Net of Commission		Net of Commission		Net of Commission		Net of Commission		Net of Commission																																	
41 National Additional Commission Disclosure	In addition to the commission enumerated above, Aon may earn additional compensation of .5% to 4% paid by one or more of the vendors identified as part of Aon's National Additional Commission Program. If the Vendor(s) you ultimately choose to provide coverage has a National Additional Commission agreement with Aon, disclosure will be included in our Comprehensive Disclosure Statement (CDS), prior to the time we seek your consent to bind your insurance program.																																													
42 National Additional Commission Included	N/A		N/A		N/A		N/A		up to 7%		N/A		N/A																																	
43 DISCLAIMER: The financial and benefit information outlined in this summary has been prepared for you to use as an "at-a-glance" reference. It is intended for summary purposes only. In all cases only the official plan documents control the administration and operation of the plans.																																														

FSA - RFP Response Page 1 of 1

	A Flex-Plan Services Incorporated Stand Alone Provider	B Total Administrative Services Corporation (TASC) Stand Alone Provider	C ASI Flex Stand Alone Provider	D United HealthCare Tied to Medical Quote	E BCBS of NM / Connect Your Care Tied to Medical Quote	F Cigna Tied to Medical Quote	G Presbyterian / Health Equity Tied to Medical Quote
	Quote 1	Quote 2	Quote 3	Quote 4	Quote 5	Quote 6	Quote 7
1 Initial Set-up Fee	Waived	Waived	Waived	Waived	\$125	None	Waived (Presbyterian covering fee)
2 Monthly Fee - FSA & DCAP (per participant per month)	\$4.25 if purchased with COBRA services; \$4.75 if purchased separately	\$4.00 with TASC Card; \$4.25 without TASC Card	\$2.95 or \$50 monthly minimum	\$5.78 or \$100 monthly minimum	\$2.22	\$5.79 PEPM	\$3.95
3 Debit Card	\$5.00 fee for replacement or additional card	\$10.00 replacement card	\$5.00 replacement or additional card	\$0.50 per participant per month	Included	Included	3 Cards included; \$5 for additional cards
4 Plan Documents	A legal plan document and SPD are provided at the start of the plan year and updated each year as needed. Printed SPDs are \$3.50 per SPD produced and provided to each participant	Included	Included	Included	Provides a plan document template	Included	Included
5 Plan Amendments	Included except if there are extensive changes then \$150 fee	Included	Included	Included	Templates are provided	Included	No fee if changed at renewal
6 Nondiscrimination Testing	Included	Included	Included	\$500.00 Per Testing Occurrence	\$250 fee for FSA testing	Cigna does not perform non-discrimination testing	Included
7 Annual Renewal Fee	Waived	None	Waived	None	None	None	\$250-\$300 depending on participants
8 Additional Fees	Local attendance at enrollment meetings and benefit fair beyond the first three (3) is charged at a rate of \$75/meeting	HIPAA Compliance: \$400 first year; \$100 renewal fee per year	Open Enrollment Meetings: two consecutive days at no additional charge (first year only) \$250 per day, each additional day	Imprest Balance Required: \$5,000	Special requests and projects: \$200 per hour	Enrollment Materials and Forms - provides enrollment materials including worksheets and an online calculator	Enrollment Materials Included
	Enrollment materials are included	Electronic enrollment materials are included	Enrollment materials provided in PDF format; ASI's website includes videos, eligible expense listing, expense estimate and tax savings calculator, FAQs, etc.	Enrollment Materials and Forms: provides printed or electronic forms	Enrollment Meeting Support: \$800 per day, plus normal travel and expenses		
		Open Enrollment Meetings: up to 4 onsite meetings included. Additional onsite meeting attendance: \$350 per day plus travel		Open Enrollment Meeting Support: No charge	Printed Open Enrollment Materials: additional cost depending upon customization and paper		
					Takeover of account administration from previous plan year will be billed for three months at 150 percent of active monthly administrative fee rate.		

COBRA - RFP Response Page 1 of 1

	A Flex-Plan Services Incorporated Stand Alone Provider	B Total Administrative Services Corporation (TASC) Stand Alone Provider	C ASI COBRA Stand Alone Provider	D United HealthCare Tied to Medical Quote	E BCBS of NM Tied to Medical Quote	F Cigna - Allegiance COBRA Services, Inc. Tied to Medical Quote	G Presbyterian Health Plan / Conexis Tied to Medical Quote
	Quote 1	Quote 2	Quote 3	Quote 4	Quote 5	Quote 6	Quote 7
1 Initial Set-up Fee	Waived	Waived	\$250	N/A	None	\$250	
2 Monthly Fee (per participant per month)	Base Fee: \$0.70 PEPM if purchased with FSA; \$0.75 if purchased separately Pro-rated or Age-banded Plan Fee: \$20.00/month	Admin Fee: \$0.65 per COBRA Continuant per month or \$85.00 <i>whichever is greater</i>	\$5.00 per participant per month or \$50 minimum	\$0.45 Per Employee Enrolled in the Medical Plan Per Month	\$75 per month per group account	Monthly Minimum \$100	\$0.54 per employee per month
3 COBRA Administration Fee	2% Retained by FPS	2% retained by TASC	2% retained by ASI	2% retained by City of Santa Fe	2% retained by City of Santa Fe	2% retained by ACS	
4 Annual Renewal Fee	Waived	None	\$250	Included	None	\$100	
5 Additional Fees	Notifications Required by Legislative Changes: \$10.00 per letter	General Initial Rights Notice to all current employees: \$0.65 per benefit eligible	Initial COBRA Notifications: \$3.00 per mailing	Initial COBRA Rights Notice: \$3.00 per notice	Notification Fee: \$10 per notification packet sent out	Initial COBRA Rights Notice: \$2.50 per notice	
	Manual Data Entry: \$5.00 per participant (Applies to all election and general notice submissions by fax or email)	Open Enrollment (distribution of materials): \$15.00 per packet	COBRA Qualifying Event Notification: \$15.00 per notice	Open Enrollment (distribution of materials): \$8.00 plus postage	\$10 per month per active COBRA participant	\$13 per month per active COBRA participant	
	Special Handling: \$15.00 per occurrence		Open Enrollment (distribution of materials): \$8.00 plus postage	UHC provided the option to pay fees on a per event pricing: \$4.50 - ongoing COBRA Continuant Per Month Charge \$14.50 - Qualifying Event Notification \$3.00 - COBRA Initial Rights Notice		COBRA Election Notices - \$15.00 per notice	
	COBRA Mass Mailings: \$50.00 plus \$5.00 per notice for a mass mailing of the COBRA initial notice to all employees and covered spouses Open Enrollment: \$20.00 fee per enrollment kit mailed plus postage to a COBRA family unit						

DRAFT FOR REVIEW & REDLINE PURPOSES ONLY

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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**Client Name: City of Santa Fe
Administrative Services Only DRAFT Agreement**

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.

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Section 1. Term and Termination of Agreement

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

- i. The date which is at least sixty (60) days from the date that either Party provides written notice to the other Party of termination of 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

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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.

Deleted: Payments received after the last day of the month in which they are due, shall be subject to late payment charges, from the due date at a rate calculated as follows: the one (1) year Treasury constant maturities rate for the first week ending in January plus five percent (5%). For purposes of calculating late payment charges, payments received will be applied first to the oldest outstanding amount due. CHLIC may reasonably revise the methodology for calculating late payment charges upon thirty (30) days' advance written notice to Employer.¶

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

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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.

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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

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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. _____
- 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.

Deleted: CHLIC shall have the right to revise the charges identified in this Agreement (i) on the first anniversary of this Agreement and at any time thereafter by giving Employer at least sixty (60) days' prior written notice, but not more frequently than once in a twelve (12) month period, (ii) upon any modification or amendment of the benefits under the Plan, (iii) upon any variation of fifteen percent (15%) or more in the number of Members used by CHLIC to calculate its charges under this Agreement, and/or (iv) upon any change in law or regulation that materially impacts CHLIC's liabilities and/or responsibilities under this Agreement.

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.

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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

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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

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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

Deleted: Catherine Raveling, Finance Director

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.

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Client Name: City of Santa Fe
Administrative Services Only *DRAFT* Agreement

SIGNATURES

Deleted: SIGNATURE AREAS HAVE BEEN INTENTIONALLY DELETED FROM THIS DRAFT AGREEMENT PROVIDED FOR REDLINE AND REVIEW PURPOSES ONLY

CITY OF SANTA FE: _____ CIGNA HEALTH AND LIFE INSURANCE CO. _____

JAVIER M. GONZALES, MAYOR

NAME & TITLE

DATE: _____

DATE: _____

ATTEST:

YOLANDA Y. VIGIL, CITY CLERK

APPROVED AS TO FORM:

K *MG* 4/22/15

KELLEY A. BRENNAN, CITY ATTORNEY

APPROVED:

OSCAR RODRIGUEZ, FINANCE DIRECTOR

Business Unit/Line Item: _____

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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 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
<ul style="list-style-type: none"> Cigna Choice Fund Health Reimbursement Account (HRA) Administration 	<p>\$4.94/employee/month Non-COBRA Only Included in Medical Administration Charge</p> <p>For HRA OAP (All Plans) Included in Medical Access Fee</p>
<p>Health Advisor - A</p> <p>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:</p> <ul style="list-style-type: none"> 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 	
AMOUNTS OWED TO CHLIC	
<p>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.</p>	

CIGNA PHARMACY BENEFIT MANAGEMENT SERVICES CHANGES 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
<ul style="list-style-type: none"> • Cigna Pharmacy Product Administration Fee: Included in Medical Administration Charge
CHARGES FOR DRUGS COVERED UNDER THE PLAN'S PHARMACY BENEFIT
<p>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:</p> <p>Brand Drug Claims: AWP minus an average discount of 20%.</p> <p>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%.</p> <p>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.</p> <p>Home Delivery Drug Claims: An average dispensing fee of no more than \$0.00</p> <p>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:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

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
<p>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:</p> <p>\$26.27 per Retail Pharmacy Brand Drug Claim and \$128.01 per Mail Service Pharmacy Brand Drug Claim.</p> <p><u>Caveats:</u></p> <ol style="list-style-type: none">(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. <p>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.</p>
AUDIT RIGHTS RELATED TO MANUFACTURER PAYMENTS
<p>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.</p>

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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 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	

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	<ul style="list-style-type: none"> Line Item Analysis Professional Fee Negotiation 	Lesser of 5% of hospital bill or the savings achieved
	<ul style="list-style-type: none"> Professional Fee Negotiation 	29% of net savings
	Outpatient Hospital Bill Review	
	<ul style="list-style-type: none"> Professional Fee Negotiation 	29% of net savings
	<ul style="list-style-type: none"> Line Item Analysis Re-pricing 	29% of net savings
	Physician/Professional Bill Review	
	<ul style="list-style-type: none"> Professional Fee Negotiation 	29% of net savings
	<ul style="list-style-type: none"> Line Item Analysis Re-pricing 	29% of net savings
4.	<p>Medical Bill Review – (Pre or Post-payment Cost Containment for Non-contracted and Contracted claims):</p> <ul style="list-style-type: none"> Bill Audit 	29% of the savings/recovery achieved plus hospital fees or expenses passed through
	<p>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.</p>	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	30% of recovery
9.	Pharmacy Vendor Recoveries	30% of recovery
10.	Class Action Recoveries	35% of recovery

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DENTAL COST CONTAINMENT	
Dental Cost Containment	25% of gross savings
CARE MANAGEMENT/COST CONTAINMENT PROGRAM FEES	
<p>CHLIC arranges for third parties to provide care management services to:</p> <ul style="list-style-type: none"> (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. 	<p>Specific vendor fees and care management program services are available upon request.</p>
ELIGIBILITY OVERPAYMENT RECOVERY FEES	
<p>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).</p>	29% of recovery
EXTERNAL REVIEW AND CONSULTATIVE REVIEW FEES	
<p>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.</p>	\$500-\$4,000 Review
STRATEGIC ALLIANCES	
<p>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.</p>	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.
	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.
	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.
2.	Provide SBC, translation notices prepared by CHLIC to Employer electronically as well as any updates or material modifications.
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.
	NO CHARGE
	NO CHARGE
	\$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	<p>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.</p> <p>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.</p> <p>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.</p> <p>The program includes the following components for those with a chronic condition:</p> <ul style="list-style-type: none"> • Chronic condition-specific coaching • Pre- and post-discharge calls • Lifestyle management coaching: stress, weight management and tobacco cessation • Treatment decision support and coaching <p>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.</p>	<p>Included at No Additional Cost</p> <p>For OAP and HRA OAP Products: Included in Medical Access Fee</p>
Your Health First		

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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.

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Exhibit B – Services

BANKING AND ADMINISTRATION		
Products excluding Health Savings Account		
1.	Furnishing CHLIC's standard Bank Account activity data reports to Employers 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 6041 of 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

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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

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Health Reimbursement Account (HRA), Health Awards (HA) and Healthy Future (HF) Only		HRA Product
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

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	HRA Product	HRA Product
10.	<p>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.</p>	<p>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.</p>
11.		

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PLAN BOOKLET	
Products excluding Health Savings Account	
Prepare and make accessible Member benefit booklet drafts to Employer.	All Products
UNDERWRITING SERVICES	
1. 5500 Schedule C reporting.	All Products
2. 5500 Schedule A or Annual Reconciliation Disclosure reporting (when applicable)	All Products
3. CHLIC's standard Underwriting services: a) benefit design analysis-b) projected cost analysis.	All Products
HIPAA INDIVIDUAL RIGHTS	
Products excluding Health Savings Account	
Handling of requests from Members for access to, amendment and accounting of protected health information, and requests for restrictions and alternative communications as required under federal HIPAA law and regulations, as set out in this Agreement and its Exhibits.	All Products
COST CONTAINMENT	
1. Maximum reimbursable charge determinations of non-Participating Provider charges for covered services.	All Medical Products (with out-of-network benefits)
2. CHLIC's standard cost containment controls: Application of non-duplication and coordination of benefits rules and coordination with Medicare.	All Medical Products
3. Delivery of information, as necessary, regarding standard application of non-duplication or coordination of benefits.	All Medical and Dental Products
4. Review of medical bills in accordance with CHLIC's then current Medical Bill Review program.	All Medical Products
5. Dental Cost Containment, a network of additional participating PPO providers that provide discounts for which CHLIC retains a portion of the savings generated.	All Dental Products
6. Network Savings Program, a national vendor network that provides discounted rates when a Member accesses care through a Network Savings Program contracted provider.	All Medical Products
7. Annual reporting of CHLIC's standard cost containment results upon Employer's request.	All Medical and Dental Products
8. Pharmacy Vendor Recoveries.	All Pharmacy Products

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CUSTOMER REPORTING		
1.	Summary reports of medical, dental and pharmacy cost and utilization experience are available through Cigna's web site, CignaAccess.com.	All Medical, Dental and Pharmacy Products
2.	CHLIC's standard pharmacy utilization reports.	Pharmacy Product Only
3.	Claim Reporting: CHLIC will provide standard banking and financial report information based upon paid claim data. CHLIC will not provide information on incurred-but-not-reported claims, projected claims, pre-certifications of coverage, case management information or information on a Member's prognosis or course of treatment. Stop Loss Reporting is an optional service provided at an additional fee to Employers who have stop loss through another entity other than CHLIC. CHLIC will provide its standard reporting only after the stop loss carrier and Employer have executed CHLIC's standard Hold Harmless/Confidentiality Agreement.	All Medical Products
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		
1.	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: 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.	

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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 SM 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 SM 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

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	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:		
13.	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	
<p>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.</p>	<p>These services are included in the following products: OAP and HRA OAP</p>
CIGNA STAFF MODEL HEALTH PLAN SERVICES	
<p>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.</p> <p>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).</p> <p>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.</p> <p>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.</p>	<p>All Medical Products</p>

**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

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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.

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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.

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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: _____

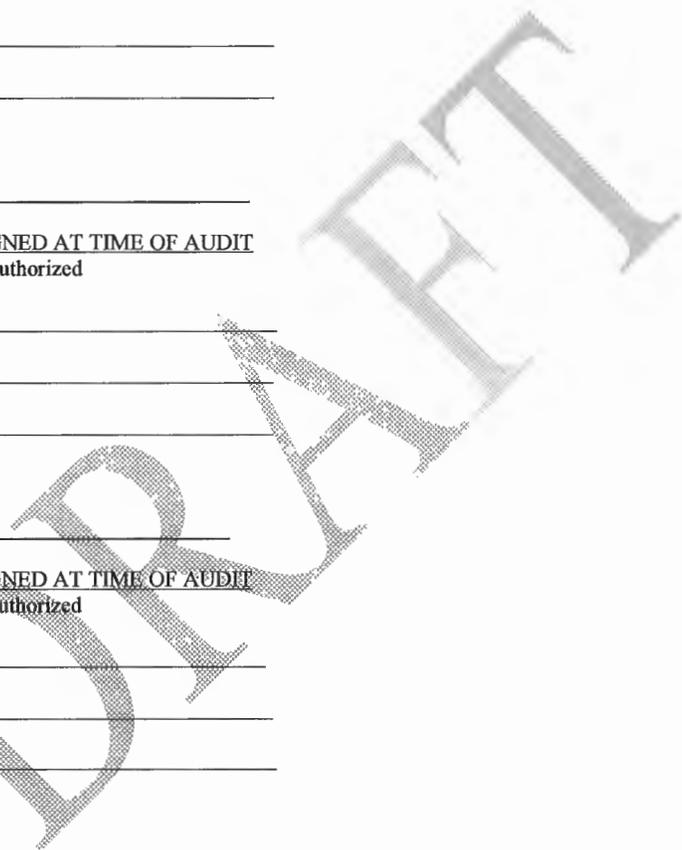
Auditor: _____

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date: _____



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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

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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

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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.

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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:

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- (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.

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“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.

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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 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. 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.

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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.

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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.

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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%

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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	ELLENC	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%

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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%

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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-CHEMOTHERAPY	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%

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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%

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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	HEMOPHIL 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	TRETEN	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%

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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%

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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%

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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	DYSPORE	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%

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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%

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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%

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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%

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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%

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**Client Name: City of Santa Fe
Administrative Services Only DRAFT Agreement**

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	VINCISTINE	34.65%
CANCER - CHEMOTHERAPY	VINCISTINE 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%

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04/23/2015

Client Name: City of Santa Fe
 Administrative Services Only *DRAFT* Agreement

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%

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04/23/2015

COBRA ADMINISTRATIVE SERVICES AGREEMENT

This Agreement is made between Allegiance COBRA Services, Inc., (hereinafter "the TPA"), and City of Santa Fe (hereinafter "Employer").

WHEREAS, the Employer and/or the plan administrator of the group health plan sponsored by the Employer is required to perform certain duties pursuant to continuation of benefits coverage requirements.

WHEREAS, the TPA has been chosen by Employer to perform nondiscretionary and ministerial duties pursuant to Employer's continuation of coverage requirements.

NOW THEREFORE, in consideration of the terms and conditions hereinafter set forth, the parties agree as follows:

SECTION 1: Definitions

- 1.1 "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985 or the Public Health Service Act, as amended or interpreted from time to time, and applicable regulations; or as defined by other Federal or State law, as amended or interpreted from time to time.
- 1.2 "COBRA Participant" means any person who is properly enrolled for and entitled to benefits from the Plan, pursuant to COBRA continuation coverage.
- 1.3 "Employer" means the plan sponsor as defined by ERISA or other applicable law and/or any successor organization or affiliate of such Employer which assumes the obligations of the Plan and this Agreement.
- 1.4 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended or interpreted from time to time, and all applicable regulations.
- 1.5 "Fee Schedule" means the listing of fees or charges for services provided under this Agreement contained in Appendix A, Fee Schedule, and incorporated by reference herein as a part of this Agreement.
- 1.6 "Force Majeure Event" means any event or condition not reasonably foreseeable as of the date of this Agreement and not reasonably within the control of the party, which prevents the party from performing its obligations under this Agreement, including natural disaster, labor unrest, civil disobedience, acts of war (declared or undeclared), or actions or decrees of governmental bodies.
- 1.7 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended and all applicable regulations.
- 1.8 "Plan" means the health and welfare benefit plan, which is the subject of this Agreement and which the Employer has established pursuant to a plan document, a self-funded trust or a policy of group health insurance.
- 1.9 "Plan Administrator" means the person or entity, including an insurance company, designated by the Employer or plan sponsor to manage the Plan and make all discretionary decisions regarding Plan terms and managing Plan assets, as defined in ERISA or other applicable law.
- 1.10 "Qualified Beneficiary" means a covered person under the Plan, who is eligible to continue coverage under the Plan in accordance with the applicable provisions of COBRA or ERISA, regarding Qualified Medical Child Support Orders, or in accordance with any other applicable Federal or State law.

“Qualified Beneficiary” also means a child born to, adopted by or placed for adoption with a covered employee or former employee, at any time during active COBRA continuation coverage of that employee or former employee.

1.11 “Qualifying Event” means:

- a. With respect to a covered employee or former employee, termination of employment of the employee (except for termination as result of gross misconduct), or reduction of hours of employment causing the employee to become ineligible for coverage.
- b. With respect to an eligible dependent of a covered employee or former employee, termination of the employee’s employment (except for termination as result of gross misconduct); reduction of hours of employment causing the employee to lose eligibility for coverage; employee’s entitlement to Medicare under certain circumstances; death of the employee, divorce or legal separation of the spouse from the employee; and an eligible dependent who ceases to be a dependent as that term is defined by the Plan.
- c. With respect to eligible retirees and their eligible dependents, the commencement of a bankruptcy proceeding.
- d. Any other qualifying event as defined by law and as the law may be amended or interpreted from time to time.

SECTION 2: Relationship of Parties

Employer acknowledges that the TPA is an independent contractor for purposes of this Agreement. As such, the TPA is not an agent or employee of Employer and does not assume any liability or responsibility for any breach of duty or act of omission by Employer.

Employer further acknowledges that the performance of services by the TPA does not and is not intended to make the TPA the “plan administrator”, “plan sponsor”, or “other fiduciary” as defined under ERISA or other applicable law, and Employer will not identify or refer to the TPA or any of its affiliates as such. The TPA has no discretionary authority or responsibility in administration of the plan(s).

Employer further acknowledges and agrees that the TPA will not be deemed to be providing legal or tax advice as a result of performing its duties under this Agreement.

Employer and/or the Plan Administrator at all times relevant to this Agreement retain fiduciary liability for administration of the services provided under this Agreement.

SECTION 3: Responsibilities of Employer for COBRA Administration

3.1 Qualifying Event Notice: As applicable, the Employer or Qualified Beneficiary will notify the TPA or cause the TPA to be notified when employees and/or their dependents have a Qualifying Event as follows:

- a. Within thirty (30) days of the employee's death, termination from employment for any reason including gross misconduct, or reduction of employment hours.
- b. Within sixty (60) days of the divorce or legal separation of the employee or the date at which a dependent child ceases eligibility under the Plan.
- c. Within sixty (60) days of a second Qualifying Event of a Qualified Beneficiary dependent or spouse, such as the divorce or legal separation from the covered employee, death of the covered employee, or a dependent child ceasing eligibility under the Plan.

- 3.2 Late Notice of Qualifying Event: If any employee or dependent of an employee provides notice to the Employer of divorce or legal separation, entitlement to Medicare, or that a dependent child ceases eligibility under the Plan, and such notice is made more than sixty (60) days after the Qualifying Event, Employer will notify the TPA in writing of the same within ten (10) days after receiving the notice. The TPA will not enroll those persons who provided notice in such manner for COBRA continuation coverage, unless specifically directed to do so in writing, by the Employer and/or the Plan Administrator.
- 3.3 Qualified Beneficiary Information: Employer will provide the TPA the following information with the Qualifying Event notice and the Initial Notice (if applicable):
- a. Name, address, date of birth, Social Security number and identification number (if different from Social Security number) of the employee.
 - b. Name, address, date of birth and Social Security number for any covered dependents.
 - c. Date and description of the Qualifying Event, or if not a Qualifying Event, the date and reason, if known, for dropping or terminating Dependent coverage. If Employer knows that the Participant's reason for dropping or terminating Dependent coverage is in contemplation of divorce or legal separation, Employer shall notify the TPA of the same.
 - d. If received by Employer, the COBRA Election Form, recorded with the date upon which Employer received the completed form.
 - e. Name or number of all benefit plans under which the Qualified Beneficiary was covered on the day immediately prior to the date of the Qualifying Event.
- 3.4 SSI Determination Letters: Employer will forward copies of any Social Security Disability Determination letters it may receive from COBRA Participants within ten (10) days after Employer receives the same and has date stamped receipt of the letter.
- 3.5 Open Enrollment: Employer will notify the TPA of any open enrollment anticipated or regularly held for employees under Employer's Plan at least forty-five (45) days prior to any such open enrollment period.
- 3.6 Employer Plan, Changes, and Amendments: Employer will notify the TPA of any changes in group health insurance carrier, benefits, eligibility and/or premiums for Employer's Plan, at least thirty (30) days prior the effective date of any such change.

If applicable, Employer will provide to the TPA, at Employer's expense, copies of the Summary Plan Description (SPD) for its Plan, and changes, modifications, or amendments to the SPD within thirty (30) days of the change or modification, for the TPA to distribute copies of the same to all COBRA participants of the Plan. A copy of the SPD in effect on the date this Agreement is executed will be provided within twenty (20) days of that date.

- 3.7 COBRA Premiums: Employer will determine the amount to be charged for COBRA premiums and notify the TPA of the same, in writing, upon execution of this Agreement. Employer will notify the TPA in writing of any premium changes at least thirty (30) days prior to the effective date of the change or as soon as reasonably possible thereafter. If Employer calculates COBRA premiums using an actuarial method, Employer will provide documentation indicating the method of calculation, and the identity of the actuaries who provided the calculations.
- 3.8 COBRA Election Forms: If Employer receives requests for COBRA coverage, Employer will record on the form the date it was received by Employer. Employer will fax a copy of the form to the TPA on the date it is received by Employer, and will mail a copy of the same to the TPA within three (3) Working Days of receipt by Employer.
- 3.9 Premium Account: COBRA Participants will be directed to send premium payments to the TPA for deposit into a TPA owned COBRA premium account. For any premiums made payable to the Employer, the Employer authorizes the TPA to endorse COBRA premium payments received by

stamping the same with “FOR DEPOSIT ONLY” and the applicable COBRA premium account number and to deposit the payments into the COBRA premium account. The COBRA premium account is not a Trust account, and the TPA is not and shall not be designated in any manner a Trustee for the account.

- 3.10 Payment of Premiums to Plan/Insurance Carrier: Employer shall pay COBRA premiums monthly for all enrolled COBRA Participants to the applicable group plan or insurance carrier. Employer shall have sole responsibility and liability to insure that premiums are paid in such a manner that insures that coverage does not lapse. Employer agrees that the sole responsibility of the TPA is to forward any COBRA premiums received in accordance with Subsections 4.6 and 4.7.

Employer will execute any documents or forms related to submission of premiums which are required by the group health plan or insurance carrier and mail the same to Employer’s group health plan or insurance carrier.

- 3.11 Premium Payments by COBRA Participants: If Employer or Employer’s Plan or insurance carrier receives premium payments directly from COBRA Participants, Employer will notify the TPA in writing, or cause the TPA to be notified in writing, of the amount of the premium, the name of the COBRA Participant for whom the premium applies, the date the premium was received, and the time period for which the premium applies. Employer, its Plan or insurance carrier will notify the TPA on the date the premium is received. Employer and the TPA will establish a system to insure premiums paid are credited to the proper COBRA Participant.

Employer will notify the TPA of any default in premium payment by any COBRA Participant, including the date of default.

- 3.12 Initial Grace Period: Employer designates that the initial forty-five (45) day grace period for the premium payment will begin on the date of COBRA election.

- 3.13 Plan Address: Employer will provide to the TPA the name and address of the enrollment department of its Plan on the date this Agreement is executed, and provide written notice to the TPA of any changes regarding the identity or address of its Plan within three (3) Working Days after such change.

- 3.14 Other: Employer will provide any other information required by the TPA to perform its obligations under this Section.

SECTION 4: COBRA Services of the TPA

- 4.1 Enrollment Packet: Within fourteen (14) days of receipt of notice from the Employer of a Qualifying Event, the TPA will mail to Qualified Beneficiaries a notice of the right to elect COBRA continuation coverage.

- 4.2 Enrollment of Qualified Beneficiaries: The TPA will enroll all Qualified Beneficiaries who elect COBRA continuation coverage within the time permitted by law. The TPA will send copy of each completed enrollment form to the Employer and/or Plan Administrator for Employer’s Plan, within five (5) Working Days of receipt of the completed enrollment form via fax or secure email as designate by the Employer. After transmission of the completed enrollment form by the TPA, the Employer or the Plan Administrator shall be solely responsible for ensuring that the Qualified Beneficiary’s COBRA continuation coverage timely begins.

- 4.3 Plan Changes and Amendments: The TPA will inform COBRA participants under the Plan of any changes in benefits, eligibility requirements, or premiums of the Plan, provided, however, that the TPA receives written notice from Employer as required by this Agreement. The TPA’s obligation under this subsection will be limited to mailing to COBRA participants, copies of all Plan amendments, changes, modifications, or other notices as provided to the TPA by Employer.

- 4.4 Open Enrollment: The TPA will notify COBRA participants of any open enrollment anticipated or regularly held for employees under Employer's Plan. Such notice will be by first class mail and will be sent within five (5) Working Days after the TPA's receipt of notice of such open enrollment from Employer.
- 4.5 Customer Service Toll-Free Line: The TPA will provide customer service assistance regarding COBRA issues to Employer and beneficiaries under Employer's Plan through a toll-free telephone number during regular business hours.
- 4.6 COBRA Participant Premiums: The TPA will bill COBRA Participants for the premiums as designated by Employer and in accordance with applicable law. The TPA will not be required to bill for any premium amount that does not comply with applicable law.

There are two options available to Employer for collection of premium by TPA, one of which must be designated by employer upon execution of this Agreement. Those options are:

- a. The TPA will collect COBRA premiums, and deposit them in the designated COBRA premium account no less frequently than weekly. If the TPA receives premium checks made payable to the Employer, the TPA will endorse them with "FOR DEPOSIT ONLY", without recourse, and deposit them into the COBRA premium account.

By the tenth of each month, the TPA will forward all premiums collected for the previous month, which were deposited and held in the COBRA premium account, to the Employer via ACH transfer.

- b. Participants will be directed to make premium payments payable to the Employer. If payments are received by the TPA which are payable to the TPA, the TPA will endorse them to Employer, without recourse.

The TPA will collect COBRA premiums and forward them to Employer no less frequently than bi-weekly via First Class Certificate of Mail. Upon placing the checks in the mail, the TPA will have no further liability or responsibility with respect to these premium checks. The TPA will establish, or cause to be established, a system to credit the premium payments to the appropriate Qualified Beneficiary or COBRA Participant.

- 4.7 Late Premium Notices: The TPA will send a reminder notice to Qualified Beneficiaries whose premium payment has not been received on or about the twentieth day of the month.
- 4.8 Late Premium Payments: If the TPA receives a premium payment past the premium due date (including any grace period provided by law or the Plan), the TPA will return the payment to the sender with a notice that it cannot be accepted. The TPA will return the payment to the sender, with such notice, within five (5) Working Days of receipt of payment.

The TPA will notify Employer and/or the Plan Administrator in writing of any COBRA Participant who defaults on payment of premium, including date of default and the date COBRA coverage should terminate as a result of the default. Such notice will be faxed on the next Working Day following the date of the default.

- 4.9 Notice of Eligibility: The TPA will provide all notices of eligibility or lack thereof to employees and their dependents as required by applicable law, including but not limited to notice of ineligibility for COBRA continuation coverage due to termination of employment for gross misconduct, and notice of potential eligibility for a dependent spouse in the event of legal separation or divorce.
- 4.10 Notice of Termination or Exhaustion: The TPA will notify the Employer and/or Plan Administrator and the COBRA Participant of the date COBRA continuation coverage will exhaust or terminate in the absence of any default, for each COBRA Participant. Notice will be sent via fax or email to the

Employer and/or Plan Administrator within five (5) Working Days after the TPA receives notice of COBRA coverage exhaustion or termination. Notice of exhaustion or termination will be sent by first class mail to the COBRA Participant within 30 days of the termination date.

- 4.11 Notice of Default: The TPA will notify each COBRA Participant, in writing, of any default causing loss of coverage, including the date of default and the date COBRA continuation coverage terminates. Such notice will be based upon information provided by Employer or Plan Administrator. Notice will be sent by first class mail within five (5) Working Days following receipt of notice from Employer or Plan Administrator.
- 4.12 Employer Reports: The TPA will provide a monthly eligibility report to the Employer. The TPA shall also prepare and submit a monthly premium reconciliation report to the Employer.
- 4.13 Notice of State Continuation Coverage: The TPA will provide notices to eligible COBRA Participants of their rights to obtain state continuation coverage. The TPA shall notify eligible COBRA Participants of their rights to elect state continuation coverage within ninety (90) days of the date of termination of the COBRA Participant's continuation coverage benefits under federal COBRA continuation law. Upon receipt of the completed election form from the eligible COBRA participant, the TPA will enroll the COBRA participant, bill for premiums, and process premium payments in accordance with Section 4.
- 4.14 Conversion Coverage: If the Plan allows conversion rights or other such similar rights, the notices will be supplied by the insurance carrier or Plan providing such coverage, at no cost to the TPA. Notices will be provided in the manner required by the insurance carrier or Plan. The TPA will have no other responsibility, except as specifically stated in this subsection, regarding conversion coverage.

SECTION 5: TPA Compensation

Employer agrees to pay the TPA its compensation for services provided under this Agreement in accordance with the terms and conditions of Appendix A, Fee Schedule and Financial Arrangement.

SECTION 6: Exclusions

- 6.1 Illegal Acts: No party hereto will be required to perform any act or omit any act which would be a violation of any law or regulation, unreasonably expose a party to civil liability, or which violates any code of ethical conduct.
- 6.2 Benefits Advice: The TPA will not provide any benefits advice or benefits verification to COBRA Participants or health care providers and will refer all such inquiries to the Employer or the Plan Administrator.
- 6.3 Payment of Claims: The TPA will not provide customer services or information to any person regarding payment or nonpayment of claims by the Plan, and will refer all such inquiries to the Employer or Plan Administrator.
- 6.4 NSF Checks: This Agreement will not be construed in any manner to require the TPA to collect insufficient funds, "stop-payment" or otherwise dishonored checks, or other negotiable instruments received for premium payments, which are subsequently not paid by the maker. The TPA will not be liable for any losses to Employer or Employer's Plan as a result of such checks or negotiable instruments.
- 6.5 Determinations of Gross Misconduct: The TPA will not make any determinations of any nature regarding whether a Qualified Beneficiary's termination from employment was due to gross misconduct.

SECTION 7: Indemnification

- 7.1 Misconduct of Party: Neither party will be responsible for the negligence, gross negligence, and intentional, willful or criminal acts of the other in any manner. Either party who commits such a negligent, grossly negligent, willful, intentional or criminal act will indemnify and hold the other harmless for all damages or costs, including attorney fees, or regulatory fines or surcharges incurred as a result of that act. In no event will any party to this agreement be subject to incidental or consequential damages for any reason whether such damages were foreseeable or not.
- 7.2 Premium Payments/Loss of Coverage: The TPA will receive and forward all premium payments in accordance with this Agreement. Except as provided for in Subsection 4.6, the TPA will have no liability regarding the processing of premium payments. Provided the TPA acts in accordance with this Agreement, the TPA will have no liability to any person or entity for loss of COBRA coverage as a result of late or nonpayment of premium. Employer will hold the TPA harmless, and indemnify the TPA for all damages, including payment of attorney fees and costs of defending any claim, regarding all claims or suits by persons for loss of COBRA coverage as a result of late or nonpayment of premium.
- 7.3 Failure of Employer to Notify: The TPA will provide all notices to COBRA participants and Qualified Beneficiaries in accordance with this Agreement. Provided the TPA acts in accordance with this Agreement, the TPA will have no liability to any COBRA participant or Qualified Beneficiary for failure of the Employer to properly notify the TPA and provide the information required for the TPA to perform its obligations under this Agreement. The TPA will have no liability for the accuracy of the information provided by the Employer. Employer will hold the TPA harmless, and indemnify the TPA for all damages, including payment of attorney fees and costs of defending any claim, as a result of Employer's failure to properly notify the TPA and provide information to the TPA.

SECTION 8: Term and Termination of Agreement

- 8.1 Term: This Agreement begins July 01, 2015 and terminates on June 30, 2016. This Agreement will automatically be renewed for additional successive periods of one year thereafter until terminated in accordance with this section.
- 8.2 Termination: Either party may terminate this Agreement at any time, with sixty (60) days advance written notice to the other party unless both parties agree, in writing to waive such advance notice. At the option of the party initiating the termination, the other party may be permitted a reasonable cure period of a length determined by the party initiating the termination, but not to exceed forty-five (45) days to cure any default.
- 8.3 Employer Failure to Pay: The TPA may, at its sole option, terminate this Agreement with ten (10) days' written notice to the Employer, if the Employer fails to pay the fees for the TPA's services in accordance with the Fee Schedule in Appendix A.
- 8.4 Immediate Termination: Either party may, at its sole option, terminate this Agreement with ten (10) days' written notice to the other party, upon the occurrence of any one or more of the following events:
- a. Either party engages in any unethical business practice or fails to comply with any federal, state, or other government statute, rule, or regulation;
 - b. Either party, through its acts, practices, or operations, unreasonably exposes the other party to any existing or potential investigation or litigation;

- c. Either party loses any licensure or certification required by law to perform its obligations under this Agreement;
 - d. Court appointment of a permanent receiver for all or substantially all of either party's assets; or
 - e. A general assignment for the benefit of the creditors of either party; or
 - f. The filing of a voluntary or involuntary petition of bankruptcy by either party, if such petition is not dismissed within forty-five (45) days of the date of filing, provided that an order for relief from automatic stay has been obtained, or with respect to a Chapter 11 proceeding, that the bankrupt or Bankruptcy Trustee fails to reaffirm this Agreement and provide adequate assurances pursuant to 11 USC 365.
- 8.5 Force Majeure: The party affected by the Force Majeure Event shall immediately notify the non-affected party. Upon receipt of such notice by the non-affected party, all obligations under this Agreement will be immediately suspended. The party who has been so affected will do everything possible to resume performance. If, however, the period of non-performance exceeds fourteen (14) Working Days from the receipt of notice by the non-affected party, the non-affected party may, by giving ten (10) Working Days, written notice, terminate this Agreement.
- 8.6 Survival: The provisions of Section 2, Section 5, Section 7 and Subsection 9.7 shall survive termination of this Agreement.

SECTION 9: General Provisions

- 9.1 Authorization: Employer grants to the TPA the authority to do all acts it deems necessary to carry out the terms of this Agreement.
- 9.2 No Waiver: No forbearance or neglect on the part of either party to enforce or insist upon any of the provisions of this Agreement will be construed as a waiver, alteration, or modification of this Agreement.
- 9.3 Entire Agreement, Amendments, and Modification: This Agreement and any attachments constitute the entire agreement between the parties with respect to its subject matter. This Agreement supersedes all existing agreements and all other oral, written or other communications between them concerning its subject matter. This Agreement or any attachment shall not be amended or modified except as agreed upon in writing and signed by the parties. If any such modification or amendment increases the TPA's costs under this Agreement, the Employer agrees to pay any increases in administrative fees or other costs which the TPA reasonably expects to incur as a result of such modification.
- 9.4 Severability: If any provision of this Agreement is held to be invalid, illegal, or unenforceable by any court of final jurisdiction, it is the intent of the parties that all other provisions of this Agreement be construed to remain fully valid, enforceable, and binding on the parties.
- 9.5 Agreement Counterparts: This Agreement may be executed in two or more counterparts, each and all of which will be deemed an original and all of which together will constitute but one and the same instrument.
- 9.6 Assignment: Neither party shall assign or transfer in any manner its obligations, rights, interests, or any part thereof under this Agreement without the prior written consent of the non-assigning party. Any assignment in contravention of this Agreement is null and void. The foregoing shall not apply to the assignment of this Agreement to any successor in interest of the TPA, provided, however, the TPA sends prior written notice to the Employer.

- 9.7 Notice of Threatened Litigation: The Employer will notify the TPA within ten (10) Working Days of any threatened litigation, lawsuits or regulatory complaints or inquiries pertaining to subject matter of this Agreement, or any inquiry made by any federal or state authority regarding the same.
- 9.8 Compliance with Applicable Laws: The TPA shall comply with all applicable federal and state laws and regulations with respect to the services TPA expressly agrees to perform under this Agreement.
- 9.9 Notice: The TPA will not be bound by any notice, directive or request unless and until it is received in writing at this mailing address or fax number:

2806 South Garfield Street
P.O. Box 2097
Missoula, MT 59806-2097
(Fax) (406) 523-3131

Employer and/or Plan Administrator will not be bound by any notice, directive or request unless and until it is received in writing, by facsimile transmission, or by e-mail address, at its primary place of business as designated in Appendix B.

- 9.10 Choice of Law: This Agreement shall be governed by, and construed in accordance with the laws of the State of Montana, except to the extent those laws may be superseded by applicable federal law or regulation.
- 9.11 Arbitration: Any dispute not disposed of through mutual agreement will be submitted for arbitration in Missoula, Montana, or such other place selected by mutual agreement of the parties. The Arbitrator will be selected by mutual agreement of the parties. Failure to agree will result in application to the district court for appointment of the arbitrator. Any award rendered may be confirmed in district court and judgment docketed as if rendered in an action.
- 9.12 Attorney Fees: If either party breaches or defaults in the performance of their obligations under this Agreement, the breaching party will pay all reasonable attorney fees and costs incurred by the other party as a result of such breach or default.
- 9.13 Headings: Section headings are included only for convenient reference and do not describe the sections to which they relate.
- 9.14 Interpretation of Words: Words denoting the singular include the plural and vice versa.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement by their duly authorized representatives' signatures, on the date first above written.

CITY OF SANTA FE

ALLEGIANCE COBRA SERVICES, INC.

Name:
Title:

Name: **Ronald Dewsnup**
Title: **President and General Manager**

**APPENDIX A
FEE SCHEDULE AND
FINANCIAL ARRANGEMENT**

Employer and the TPA agree to the compensation schedule set forth below as the sole compensation to the TPA for performance of its obligations under this Agreement. Monthly fees are based upon Plan participant enrollment as of the beginning of the month.

- A. Initial Set-Up Fee of \$250.00 plus \$10.00 per current COBRA participant.
- B. Annual Renewal fee of \$100.00.
- C. Monthly COBRA fee which will consist of the following:
 - a. An amount equal to \$13.00 per COBRA Participant;
 - b. An amount equal to \$15.00 per Qualifying Event;
 - c. An amount equal to \$2.50 per Initial COBRA Rights Notice;
 - d. An amount equal to the two percent (2%) COBRA administrative fee assessed against the COBRA premiums; and
 - e. The TPA will calculate COBRA fees monthly at the end of each month and an invoice will be sent to Employer. If the calculation of the monthly COBRA fee for any given month is less than \$100.00, the monthly COBRA fee shall be an amount not less than \$100.00. COBRA fees are due and payable within thirty (30) days of receipt of the invoice.
- D. Hourly fee of \$100.00 for consulting. Such services must be approved and agreed to in advance, in writing, by the Employer.
- E. Hourly fee of \$50.00 for special COBRA enrollment history, statistical or archival research or reporting. Such services must be approved and agreed to in advance, in writing, by the Employer.

APPENDIX B
PLAN ADMINISTRATOR

Employer:

City of Santa Fe
2651 Siringo Road, Building H
Santa Fe, NM 87505

**BUSINESS ASSOCIATE AGREEMENT
BETWEEN
CITY OF SANTA FE
AND
ALLEGIANCE COBRA SERVICES, INC.
I. PREAMBLE**

CITY OF SANTA FE and Allegiance COBRA Services, Inc, (jointly “the Parties”) wish to enter into this Business Associate Agreement (“Agreement”) to comply with the requirements of: (i) the implementing regulations at 45 CFR Parts 160, 162 and 164 for the Administrative Simplification provisions of Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) (i.e., the HIPAA Privacy, Security, Electronic Transaction, Breach Notification and Enforcement Rules (“the Regulations”)), (ii) the requirements of the Health Information Technology for Economic and Clinical Health Act, as set forth in the American Recovery and Reinvestment Act of 2009 (the “HITECH Act”) that are applicable to business associates and (iii) the requirements of the final modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules as issued on January 25, 2013 and effective March 26, 2013 (75 Fed. Reg. 5566 (Jan. 25, 2013)) (the Final Regulations”). The Implementing Regulations, the HITECH Act, and the Final Regulations are collectively referred to in this Agreement as the “HIPAA Requirements.”

Covered Entity and Business Associate agree to incorporate into this Agreement any regulations issued by the US Department of Health and Human Services (“DHHS”) with respect to the HIPAA requirements that relate to the obligations of business associates and that are required to be reflected in a business associate agreement. Business Associate recognizes and agrees that it is obligated by law to meet the applicable provisions of the HIPAA Requirements and that it has direct liability for any violations of the HIPAA Requirements. The services to be provided by Business Associate are identified in a separate agreement between the Parties for Business Associate to provide COBRA services to Covered Entity.

II. DEFINITIONS

A. “*Breach*” shall mean, as defined in 45 CFR § 164.402, the acquisition, access use or disclosure of Unsecured Protected Health Information in a manner not permitted by the HIPAA Requirements that compromises the security or privacy of that Protected Health Information.

B. “*Business Associate Subcontractor*” shall mean, as defined in 45 CFR § 164.103, any entity (including an agent) that creates, receives, maintains or transmits Protected Health Information on behalf of Business Associate.

C. “*Electronic PHI*” shall mean, as defined in 45 CFR § 160.103, Protected Health Information that is transmitted or maintained in any Electronic Media.

D. “*Limited Data Set*” shall mean, as defined in 45 CFR § 164.514(e) Protected Health Information that excludes the following direct identifiers of the individual or of relatives, employers, or household members of the individual:

- (i) Names;
- (ii) Postal address information, other than town or city, state, and zip code;
- (iii) Telephone numbers;
- (iv) Fax numbers;
- (v) Electronic mail addresses;
- (vi) Social security numbers;
- (vii) Medical record numbers;

- (viii) Health plan beneficiary numbers;
- (ix) Account numbers;
- (x) Certificate/license numbers;
- (xi) Vehicle identifiers and serial numbers, including license plate numbers
- (xii) Device identifiers and serial numbers;
- (xiii) Web Universal Resource Locators (URLs);
- (xiv) Internet Protocol (IP) address numbers;
- (xv) Biometric identifiers, including finger and voice prints; and
- (xvi) Full face photographic images and any comparable images.

E. “*Protected Health Information*” or “*PHI*” shall mean, as defined in 45 CFR § 164.103, information created or received by a Health Care Provider, Health Plan, employer, or Health Care Clearinghouse, that: (i) relates to the past, present, or future physical or mental health or condition of an individual, provision of health care to the individual, or the past, present, or future payment for provision of health care to the individual; (ii) identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual; and (iii) is transmitted or maintained in an electronic medium, or in any other form or medium. The use of the term “Protected Health Information” or “PHI” in this Agreement shall mean both Electronic PHI and non-electronic PHI, unless another meaning is clearly specified.

F. “*Security Incident*” shall mean, as defined in 45 CFR § 164.304, the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

G. “*Unsecured Protected Health Information*” shall mean, as defined in 45 CFR § 164.402, Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by DHHS.

H. All other capitalized terms used in this Agreement shall have the meanings set forth in the applicable definitions under the HIPAA Requirements.

III. GENERAL TERMS

- A. In the event of an inconsistency between the provisions of this Agreement and a mandatory term of the HIPAA Requirements (as these terms may be expressly amended from time to time by the DHHS or as a result of interpretations by DHHS, a court, or another regulatory agency having regulatory authority over the Parties, the interpretation of DHHS, such court or regulatory agency shall prevail. In the event of a conflict among the interpretations of these entities, the conflict shall be resolved in accordance with the rules of precedence.
- B. Where provisions of this Agreement are different from those mandated by the HIPAA Requirements, but are nonetheless permitted by the HIPAA Requirements, the provisions of this Agreement shall control.
- C. Except as expressly provided in the HIPAA Requirements or this Agreement, this Agreement does not create any rights in third parties.

IV. SPECIFIC REQUIREMENTS OF BUSINESS ASSOCIATE

A. Flow-down of Obligations to Business Associate Subcontractors.

Business Associate agrees that as required by the HIPAA Requirements, Business Associate will enter into a written agreement with all Business Associate Subcontractors that: (i) requires them to comply with the Privacy and Security Rule provisions of this Agreement in the same manner as required of Business Associate, and (ii) notifies such Business Associate Subcontractors that they will incur liability under the HIPAA Requirements for non-compliance with such provisions. Accordingly, Business Associate shall ensure that all Business Associate Subcontractors agree in writing to the same privacy and security restrictions, conditions and requirements that apply to Business Associate with respect to PHI.

B. Privacy of Protected Health Information

1. *Permitted Uses and Disclosures of PHI.* Business Associate agrees to create, receive, use disclose, maintain or transmit PHI only in a manner that is consistent with this Agreement or the HIPAA Requirements and only in connection with providing the services to Covered Entity identified in the Agreement. Accordingly, in providing services to or for the Covered Entity, Business Associate, for example, will be permitted to use and disclose PHI for "Treatment, Payment and Healthcare Operations" as those terms are defined in the HIPAA Requirements. Business Associate further agrees that to the extent it is carrying out one or more of the Covered Entity's obligations under the Privacy Rule (Subpart E 45 CFR part 164), it shall comply with the requirements of the Privacy Rule that apply to the Covered Entity in the performance of such obligations.
 - (a) Business Associate shall report to Covered Entity any use or disclosure of PHI that is not provided for in this Agreement, including reporting Breaches of Unsecured Protected Health Information as required by 45 CFR § 160.410 and required by Section 4(e) (ii) below.
 - (b) Business Associate shall establish, implement and maintain appropriate safeguards and comply with the Security Standards (Subpart C of 45 CFR Part 164) with respect to Electronic PHI, as necessary to prevent any use or disclosure of PHI other than as provided for by this Agreement.
2. *Business Associate Obligations.* As permitted by the HIPAA Requirements, Business Associate also may use or disclose PHI received by the Business Associate in its capacity as a Business Associate to the Covered Entity for Business Associate's own operations if:
 - (a) the use relates to: (1) the proper management and administration of the Business Associate or to carry out legal responsibilities of the Business Associate, or (2) data aggregation services relating to the health care operations of the Covered Entity; or
 - (b) the disclosure of information received in such capacity will be made in connection with a function, responsibility, or services to be performed by the Business Associate, and such disclosure is required by law or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidential and the person agrees to notify the Business Associate of any breaches of confidentiality.

3. *Minimum Necessary Standard and Creation of Limited Data Set.* Business Associate's use, disclosure, or request of PHI shall utilize a Limited Data Set if practicable. Otherwise, in performing the functions and activities as specified in the separate agreement for services between the parties and this Agreement, Business Associate agrees to use, disclose, or request only the minimum necessary PHI to accomplish the intended purpose of the use, disclosure, or request.
4. *Access.* In accordance with 45 CFR § 164.524 of the HIPAA Requirements, Business Associate will make available to the Covered Entity (or as directed by the Covered Entity, to those individuals who are the subjects of the PHI (or their designees)), their PHI in the Designated Record Set. Business Associate shall make such information available in an electronic format where directed by Covered Entity.
5. *Disclosure Accounting.* Business Associate shall make available the information necessary to provide an accounting of disclosures of PHI as provided for in 45 C.F.R. ' 164.528 of the HIPAA Requirements by making such information available to the Covered Entity or (at the direction of the Covered Entity) making such information available directly to the individual.
6. *Amendment.* Business Associate shall make available PHI in a Designated Record Set available for amendment and, as directed by the Covered Entity, incorporate any amendment to PHI in accordance with 45 C.F.R. ' 164.526 of the HIPAA Requirements.
7. *Right to Request Restrictions on the Disclosure of PHI and Confidential Communications.* If an individual submits a Request for Restriction or Request for Confidential Communications to the Business Associate, Business Associate and Covered Entity agree that Business Associate, on behalf of Covered Entity, will evaluate and respond to these requests according to Business Associate's own procedures for such requests.
8. *Return or Destruction of PHI.* Upon the termination or expiration of the agreement for services between the parties or this Agreement, Business Associate agrees to return the PHI to Covered Entity, destroy the PHI (and retain no copies), or if Business Associate determines that return or destruction of the PHI is not feasible (a) continue to extend the protections of this Agreement and of the HIPAA Requirements to the PHI, and (b) limit any further uses and disclosures of the PHI to the purpose making return or destruction infeasible.
9. *Availability of Books and Records.* Business Associate shall make available to DHHS or its agents the Business Associate's internal practices, books, and records relating to the use and disclosure of PHI in connection with this Agreement.
10. *Termination for Breach.*
 - (a) Business Associate agrees that Covered Entity shall have the right to terminate this Agreement or seek other remedies if Business Associate violates a material term of this Agreement.
 - (b) Covered Entity agrees that Business Associate shall have the right to terminate this Agreement or seek other remedies if Covered Entity violates a material term of this Agreement.

C. Information and Security Standards

1. Business Associate will develop, document, implement, maintain, and use appropriate Administrative, Technical, and Physical Safeguards to preserve the Integrity, Confidentiality, and Availability of, and to prevent non-permitted use or disclosure of, Electronic PHI created or received from or for the Covered Entity.
2. Business Associate agrees that with respect to Electronic PHI, these Safeguards, at a minimum, shall meet the requirements of the HIPAA Security Standards applicable to Business Associate.
3. To comply with the HIPAA Security Standards for Electronic PHI, Business Associate agrees that it shall:
 - (a) Implement Administrative, Physical and Technical Safeguards consistent with (and as required by) the HIPAA Security Standards that reasonably protect the Confidentiality, Integrity and Availability of Electronic PHI that Business Associate creates, receives, maintains, or transmits on behalf of Covered Entity. Business Associate shall develop and implement policies and procedures that comply with the HIPAA Requirements;
 - (b) As also provided for in Section IV A. above, ensure that any Business Associate Subcontractor agrees to implement reasonable and appropriate safeguards to protect the Electronic PHI;
 - (c) Report to Covered Entity any unauthorized access, use, disclosure, modification, or destruction of PHI (including Electronic PHI) not permitted by this Agreement, applicable law, or permitted by Covered Entity in writing (Successful Security Incidents or Breaches) of which Business Associate becomes aware. Business Associate shall report such Successful Security Incidents or Breaches to Covered Entity as specified in Section E. 3 (a) below
 - (d) For Security Incidents that do not result in unauthorized access, use, disclosure, modification, or destruction of PHI (including for example and not limitation, pings on Business Associate's firewall, port scans, attempts to log onto a system or enter a database with an invalid password or username, denial-of-service attacks, that do not result in the system being taken offline, or malware such as worms or viruses) (hereinafter "Unsuccessful Security Incidents"), aggregate the data and, upon the Covered Entity's written request, report to the Covered Entity in accordance with the reporting requirements identified in Section E. 3. (b);
 - (e) Take all commercially reasonable steps to mitigate, to the extent practicable, any harmful effect that is known to Business Associate resulting from any unauthorized access, use, disclosure, modification, or destruction of PHI;
 - (f) Permit termination of this Agreement if the Covered Entity determines that Business Associate has violated a material term of this Agreement with respect to Business Associates security obligations and Business Associate is unable to cure the violation; and
 - (g) Upon Covered Entity's request, provide Covered Entity with access to and copies of documentation regarding Business Associate's safeguards for PHI and Electronic PHI.

D. Compliance with HIPAA Transaction Standards

1. *Application of HIPAA Transaction Standards.* Business Associate will conduct Standard Transactions consistent with 45 CFR Part 162 for or on behalf of the Covered Entity to the extent such Standard Transactions are required in the course of Business Associate's performing services under the agreement for services and this Agreement for the Covered Entity. As provided for in Section IV A. above, Business Associate will require any Business Associate Subcontractor involved with the conduct of such Standard Transactions to comply with each applicable requirement of 45 CFR Part 162. Further, Business Associate will not enter into, or permit its Subcontractors to enter into, any trading partner agreement in connection with the conduct of Standard Transactions for or on behalf of the Covered Entity that:
 - (a) Changes the definition, data condition, or use of a data element or segment in a Standard Transaction;
 - (b) Adds any data element or segment to the maximum defined data set;
 - (c) Uses any code or data element that is marked "not used" in the Standard Transaction's implementation specification or is not or is not in the Standard Transaction's implementation specification; or
 - (d) Changes the meaning or intent of the Standard Transaction's implementation specification.
2. *Specific Communications.* Business Associate, Plan Sponsor and Covered Entity recognize and agree that communications between the parties that are required to meet the Standards for Electronic Transactions will meet the standards set by that regulation. Communications between Plan Sponsor and Business Associate, or between Plan Sponsor and the Covered Entity, do not need to comply with the HIPAA Standards for Electronic Transactions. Accordingly, unless agreed otherwise by the Parties in writing, all communications (if any) for purposes of "Enrollment" as that term is defined in 45 CFR Part 162, Subpart O or for "Health Covered Entity Premium Payment Data" as that term is defined in 45 CFR Part 162, Subpart Q, shall be conducted between the Plan Sponsor and either Business Associate or Covered Entity. For all such communications (and any other communications between Plan Sponsor and the Business Associate), Plan Sponsor shall use such forms, tape formats or electronic formats as Business Associate may approve. Plan Sponsor will include all information reasonably required by Business Associate to effect such data exchanges or notifications.
3. *Communications Between the Business Associate and the Covered Entity.* All communications between Business Associate and Covered Entity required to meet the HIPAA Standards for Electronic Transactions shall do so. For any other communications between Business Associate and Covered Entity, Covered Entity shall use such forms, tape formats, or electronic formats as Business Associate may approve. Covered Entity shall include all information reasonably required by Business Associate to effect such data exchanges or notifications.

E. Notice and Reporting Obligations of Business Associate

1. *Notice of Non-Compliance with the Agreement.* Business Associate shall notify Covered Entity within twenty (20) calendar days after discovery of any unauthorized access, use, modification or destruction of PHI (including any successful Security Incident) that is not permitted by this Agreement, by applicable law, or permitted in writing by Covered Entity, whether such non-compliance is by Business Associate or by a Business Associate Contractor.

2. *Notice of Breach.* Business Associate will notify Covered Entity following discovery and without unreasonable delay but in no event later than twenty (20) calendar days following discovery of any "Breach" of "Unsecured Protected Health Information" whether such breach is by Business Associate or by a Business Associate Contractor.
 - (a) As provided for in 45 CFR ' 164.402, Business Associate recognizes and agrees that any acquisition, access, use or disclosure of PHI in a manner not permitted under the HIPAA privacy Rule (Subpart E of 45 CFR part 164) is presumed to be a Breach. As such, Business Associate shall (i) notify Covered Entity of any non-permitted acquisition, access, use or disclosure of PHI, and (ii) assist Covered Entity in performing (or at Covered Entity's direction, perform) a risk assessment to determine if there is a low probability that the PHI has been compromised.
 - (b) Business Associate shall cooperate with Covered Entity in meeting the Covered Entity's obligations under the HIPAA Requirements and any other security breach notification laws. Business Associate shall follow its notifications to the Covered Entity with a report that meets the requirements outlined immediately below.
3. *Reporting Obligations.*
 - (a) For Successful Security Incidents and Breaches, Business Associate ,--without unreasonable delay and in no event later than thirty (30) days after Business Associate learns of such non permitted use or disclosure (whether by Business Associate or by Business Associate's Contractor)—shall provide Covered Entity a report that will:
 - (1) Identify (if known) each individual whose Unsecured PHI has been or is reasonably believed by Business Associate to have been accessed, acquired, or disclosed;
 - (2) Identify the nature of the non-permitted access, use, or disclosure including the date of the incident and the date of discovery;
 - (3) Identify the PHI accessed, used, or disclosed (e.g., name, SSN, DOB);
 - (4) Identify the corrective action Business Associate (or Business Associate Contractor) took or will take to prevent further non-permitted accesses, uses or disclosures;
 - (5) Identify what Business Associate (or Business Associate Contractor) did or will do to mitigate any deleterious effect of the non-permitted access, use or disclosure; and
 - (6) Provide any other information the Covered Entity may reasonably request.
 - (b) For Unsuccessful Security Incidents, Business Associate shall provide Covered Entity, upon its written request, a report that: (i) identifies the categories of Unsuccessful Security Incidents as described in Section 4(c)(iii)(d); (ii) indicates whether Business Associate believes its (or Business Associate Subcontractor's) current defensive security measures are adequate to address all Unsuccessful Security Incidents, given the scope and nature of such attempts; and (iii) if the security measures are not adequate, the measures Business Associate (or Business Associate Subcontractor) will implement to address the security inadequacies.

V. TERM AND TERMINATION

A. The Term of this Agreement shall be effective as of July 01, 2015 and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.

B. Covered Entity and Business Associate each have a right to terminate this Agreement if the other party has engaged in a pattern of activity or practice that constitutes a material breach or violation of Business Associate's or Covered Entity's respective obligations regarding PHI under this Agreement and, on notice of such material breach or violation from the Covered Entity or Business Associate, fails to take reasonable steps to cure the material breach or end the violation.

C. If Business Associate or Covered Entity fail to cure the material breach or end the violation after the other party's notice, the Covered Entity or Business Associate (as applicable) may terminate this Agreement by providing Business Associate or the Covered Entity written notice of termination, stating the uncured material breach or violation that provides the basis for the termination and specifying the effective date of the termination. Such termination shall be effective 60 days from this termination notice.

D. Business Associate's and the Covered Entity's obligations to protect the privacy and the security of the PHI it created, received, maintained, or transmitted in connection with services to be provided under the agreement for services between the parties and this Agreement will be continuous and survive termination, cancellation, expiration or other conclusion of this Agreement or the agreement for services. Business Associate's other obligations and rights and the Covered Entity's obligations and rights upon , cancellation, expiration or other conclusion of this Agreement are those set forth in this Agreement or agreement for services between the parties.

IN WITNESS WHEREOF, the parties have caused this Business Associate Agreement to be executed on their behalf by their duly authorized representatives' signatures, effective as of the date first written above.

CITY OF SANTA FE

ALLEGIANCE COBRA SERVICES, INC.

BY: _____
NAME:
TITLE:

BY: _____
NAME:
TITLE:



LICENSE & SERVICES AGREEMENT

Benefits InsightSM

THIS LICENSE & SERVICES AGREEMENT ("Agreement") is entered into as of April 14th, 2015 (the "Effective Date") by and between City of Santa Fe ("Employer"), and Choicelinx Corporation ("Choicelinx"), a Delaware corporation, an Affiliate of Cigna Corporation. As used in this Agreement, "party" means either Employer or Choicelinx, as appropriate, and "parties" means Employer and Choicelinx.

WHEREAS, Employer is a customer of Cigna Health and Life Insurance Company and Life Insurance Company of North America ("Cigna") and desires to have Choicelinx provide Benefits InsightSM, an internet-based benefits administration, enrollment and eligibility management service to Employer to enhance Employer's ability to provide eligibility data to Cigna based on the terms and subject to the conditions set forth herein.

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

1. DEFINITIONS

Capitalized terms used in this Agreement will have the meanings given below or in the context in which the term is used, as the case may be.

- A. "Authorized User" means Employer, or an employee, consultant, independent contractor or Member who has been authorized by Employer to access Benefits InsightSM, who has received a valid password for his or her use and whose right to use such password has not terminated or expired.
- B. "Benefit Plan" means a benefit plan, including but not limited to, medical, dental insurance, life insurance, long-term and short-term disability insurance, and flexible spending plans, available to Members through Employer.
- C. "Benefit Vendor" means an entity with which Employer contracts for provision and/or management and administration of a Benefit Plan.
- D. "Employer Data" means any and all information (including without limitation, demographics, employment status, employee organizational information, claims extract information, documents, threaded discussions) provided, input or uploaded by an Authorized User using the Products.
- E. "Member" means any eligible employee of Employer or any eligible dependent of such employee who is enrolled as a member in one or more of Employer's Benefit Plans.
- F. "Product" means a Product identified in Section 2, including any maintenance releases or enhancements that may be provided to Employer from time to time under this Agreement.
- G. "Services" means the ASP Services, Implementation Services and other services (if any) provided by Choicelinx pursuant to this Agreement.
- H. "Site" means the Benefits InsightSM site and any related access points through which the Authorized Users may access the Products.

2. PRODUCTS & SERVICES

Choicelinx will provide the below Products and Services to Employer consistent with the Statement of Services attached hereto as Exhibit A. Employer and Choicelinx will cooperate as necessary to facilitate the provision of the Services by Choicelinx.

- A. **Implementation Services.** Choicelinx will provide Implementation Services to deploy the Products to Employer, including project management services throughout the course of the Implementation Services, as outlined in Exhibit A.
- B. **Application Service Provider (ASP) Services.**
 - (1) **Scope of ASP Services.** Choicelinx will, in support of Employer's use of the Products: (a) manage, administer, and monitor the ongoing operation and performance of the Choicelinx system, including the Choicelinx web application; (b) host the Site and update it to include enhancements as appropriate; (c) manage eligibility, plan selection and enrollment, and, if applicable, electronic data via an agreed upon format to and from Employer's Benefit Vendors; (d) provide access to standard payroll deduction data for use in employer's payroll system.
 - (2) **Restrictions.** The Site, Products and Services shall only be used by Authorized Users for purposes of enabling Members' online enrollment for and selection of Benefit Plans. Employer shall not allow any third party other than Authorized Users to access or use the Products, Services or the Site.
 - (3) **Password Protection.** Employer agrees to comply with the procedures specified by Choicelinx from time to time regarding obtaining and updating passwords. Passwords are subject to cancellation or suspension by Choicelinx upon the actual or suspected misuse.

3. GRANT OF LICENSE

- A. Choicelinx hereby grants to Employer during the Term a limited, nonexclusive, nontransferable right and license (without the right to sublicense) to use the Products, in object code form only, solely in the United States and solely in connection with Employer's own internal business purposes and to enable Members' online enrollment for and selection of Benefit Plans. Except as expressly authorized in this Agreement, Employer shall not rent, lease, sublicense, distribute, transfer, copy, reproduce, modify, timeshare or create derivative works of the Products, or any portion thereof, or use such as a component of or a base for other products or services.
- B. Subject to the terms of this Agreement, Choicelinx grants to each Authorized User a non-exclusive, non-transferable, revocable right and license to access and use the Site, using such Authorized User's password solely for Employer's internal business purposes or, in the case of Members, or Employer acting on a Member's behalf, solely for purposes of enabling such Members' online enrollment for and selection of Benefit Plans.
- C. Subject to the terms of this Agreement, Choicelinx grants to Employer a non-exclusive, non-transferable, revocable right and license to provide a hypertext or other type of link from the Employer intranet or internet site(s) to the Site in order to enable Authorized Users to locate the Site. Employer acknowledges that notwithstanding any such link, each Authorized User may be required to log in to the Site and re-authenticate such Authorized User's privileges to gain access to the Products and Services.

4. COMPENSATION

Fees. The product is being offered as a standard offering with the insurance products that Employer has purchased Cigna Health and Life Insurance Company and Life Insurance Company of North America ("Cigna"). However, Employer agrees to pay Choicelinx such additional fees, if any, agreed to in writing by the parties or as outlined in the Statement of Services attached hereto as Exhibit A within 30 days of the date of invoice.

5. INTELLECTUAL PROPERTY RIGHTS

- A. **Trade Secrets.** Employer acknowledges that the Products, Services and the Site, including but not limited to system screens and layouts and associated source code, constitute valuable trade secrets of Choicelinx. Employer agrees not to reverse engineer, decompile, disassemble or otherwise attempt to derive the source code for, or extract any, algorithms or procedures from the Products, the Services or the Site.
- B. **Ownership of Work Product.** Choicelinx shall be the exclusive owner of all rights, title and interest, including copyrights, in and to all software, software tools, inventions, materials and other work product (both preliminary and finished form) created by Choicelinx or its contractors under this Agreement.

6. INDEMNIFICATION

- A. ~~Each party acknowledges that it will be responsible for claims or damages arising from personal injury or damage to persons or property to the extent they result from the negligence of their employees. The liability of the City shall be subject in all cases to the immunities and limitations of the New Mexico Tort Claims Act.~~

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Deleted: General Indemnification. Each party agrees to hold harmless, indemnify and defend the other party and its and their respective officers, directors, employees, corporate affiliates and subcontractors from and against any and all damages, fines, penalties, deficiencies, losses, expenses reasonably and actually incurred (including reasonable fees and expenses of attorneys, and other reasonable fees and expenses of litigation) or liabilities (including settlements and judgments) (collectively "Losses"), resulting from third party claims arising out of or related to: (1) the gross negligence or willful misconduct of the Indemnifying Party; or (2) violation of such third party's intellectual property rights resulting from use by the Indemnified Party of the Site, the Services, the Products or the Employer Data in accordance with this Agreement. ¶

B. Indemnification Procedures. A party's indemnification obligations specified in this Agreement are conditioned upon the indemnified party promptly notifying the indemnifying party in writing of the proceeding, providing the indemnifying party a copy of all notices received by the indemnified party with respect to the proceeding, cooperating with the indemnifying party in defending or settling the proceeding, and allowing the indemnifying party to control the defense and settlement of the proceeding, including the selection of attorneys. The indemnified party may observe the proceeding and confer with the indemnifying party at its own expense.

7. TERM AND TERMINATION

- A. **Term.** The Term of this Agreement will commence on the Effective Date and terminate when: 1) Employer is no longer a Customer of Cigna because the agreement between Employer and Cigna or the insurance policy has terminated or; any other date mutually agreed by Employer and Choicelinx in writing.
- B. **Termination for Cause.** This Agreement may be terminated by either party if the other party is in material breach of this Agreement and has failed to cure such breach within sixty (60) days after receiving notice of such breach from the non-breaching party.
- C. **Post Termination.** Members will not be permitted to access and use the Choicelinx site as of the termination date. Employer and/or Benefit Vendors will be permitted "view only" access to the site for sixty (60) days after the termination date. Post termination, Employer will be charged for any reports or services agreed to by Choicelinx.

8. LAW & RESOLUTION OF DISPUTES

A. **Governing Law.** This Agreement will be governed by the laws of the State of ~~New Mexico~~, without regard to conflicts of law principles, as if this Agreement were executed and fully performed in the State of ~~New Mexico~~.

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B. **HIPAA Compliance.** Any Protected Health Information exchanged by the parties hereunder (as that term is defined pursuant to the Standards for Privacy of Individual Information, 45 C.F.R. Parts 160 and 164 and the Standards for Electronic Transactions, 45 C.F.R. Parts 160 and 162) will be treated in accordance with the Business Associate Agreement executed between and among the parties and/or Cigna.

C. **Resolution of Disputes.** Any dispute or controversy arising from or relating to this Agreement ("**Controversy**") shall be resolved exclusively pursuant to the following mandatory dispute resolution procedures:

- (1) Any Controversy 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 twenty (20) 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) days of any party's request for executive review, an executive level employee of each party shall be designated by the party to meet and confer with his/her counterpart to attempt to resolve the dispute. Each representative shall have full authority to resolve the dispute.
- (2) In the event that a Controversy has not been resolved within thirty-five (35) 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 in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Mediation.
- (3) In the event that a Controversy has not been resolved within sixty (60) calendar days of the request for mediation under Section (2) above, the Controversy shall be settled exclusively by binding arbitration. Each party shall bear its own costs and attorney's 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.

9. CONFIDENTIAL INFORMATION

Each party agrees to, and to cause affiliates and its and their respective agents (collectively, the "Recipients") to, keep confidential and not disclose to any third party any information, whether oral, written or electronic, concerning the other party or its business that comes to the knowledge of such Recipient by reason of this Agreement, except for such information that (1) is generally available to the public, (2) is available to such third party on a non-confidential basis from a source that is not prohibited from disclosing such information to such third party or (3) is developed by the Recipient independent of any information that it receives from the other party (collectively "Confidential Information").

In the event that any Recipient becomes legally compelled to disclose any Confidential Information, such Recipient shall provide the disclosing party with prompt written notice of such requirement so that Recipient may seek a protective order or other remedy or waive compliance with this Section.

10. DATA PRIVACY

Choicelinx will maintain the confidentiality of all Protected Health Information in its possession in accordance with the HIPAA and HITECH and any applicable state privacy laws.

11. GENERAL

- A. **Assignment.** Neither party may assign this Agreement without the prior written consent of the other party, except that either party may assign this Agreement to an affiliate corporation or an entity that has acquired all or substantially all of the party's assets or otherwise succeeded to the business. This Agreement will be binding upon the parties' respective successors and permitted assigns. Any assignment in contravention of this Section shall be void.

- B. **Force Majeure.** Notwithstanding any other provision of this Agreement, neither party shall be liable for any delay or failure in performance of all or any part of this Agreement (other than the obligation to pay money when due) to the extent that such delay or failure is a result of any cause beyond such party's reasonable control, including any act of God, act of government, act of civil or military authority, war, riot, terrorism, insurrection, civil commotion, embargo, labor dispute, fire, explosion, flood, accident, or interruption of power, telecommunications, or other goods or services ("**Force Majeure**"). Any such delay or failure shall suspend applicable portions of this Agreement until the Force Majeure ceases.

- C. **Relationship.** The parties intend to create an independent contractor relationship and this Agreement shall not be construed to establish any form of partnership, joint venture, franchise or agency. Neither party shall have any right, power or authority, express or implied, to bind the other.

Each party has caused its authorized representative to execute this Agreement as of the Effective Date.

Choicelinx Corporation

Employer

By: _____

By: _____

Name: Keith Scally

Name: JAVIER M. GONZALES
(Please Print)

Title: President, Choicelinx

Title: MAYOR

Date: _____

Date: _____

ATTEST:

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YOLANDA Y. VIGIL, CITY CLERK

APPROVED AS TO FORM:

KAB *4/23/15*

KELLEY A. BRENNAN, CITY ATTORNEY

APPROVED:

OSCAR RODRIGUEZ, FINANCE
DIRECTOR

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STATEMENT OF SERVICES



Exhibit A - STATEMENT OF SERVICES

Benefits Insight
For

City of Santa Fe



1 OVERVIEW

City of Shawnee has elected to implement Benefits InsightSM provided by Choicelinx, a benefits technology and services company and wholly owned subsidiary of Cigna. The online enrollment product is being offered as a standard offering with the insurance products that Client has purchased through Cigna.

This Statement of Services describes the enrollment products and services to be provided by Choicelinx.

2 ONLINE ENROLLMENT PRODUCTS

Choicelinx is providing access to its standard online enrollment product which includes an Employee self-service portal to support annual enrollment and new hire events for the active employee population; and an HR/Benefit Administrator portal that is available to authorized Client's benefit administrators to support enrollment and year round eligibility management. COBRA Participants and Retirees may be included by exception.

These products will support the following benefits*:

Benefit Type	Carrier	Plan Names
Medical	Cigna	Choice Fund HRA Open Access Plus Open Access Plus - Core Plan Open Access Plus - Premium Plan
Dental	Cigna	Dental PPO
Vision	Cigna	Cigna Vision
Flexible Spending Accounts	Cigna	Medical Flexible Spending Account Dependent Care Spending Account
Life & AD&D**	Cigna	Basic Employee Life Basic Dependent Life Voluntary Employee Life Voluntary Dependent Life Basic Employee AD&D Voluntary Employee AD&D Voluntary Family AD&D
COBRA***	Allegiance	Allegiance COBRA

Comment [PM51]: CI decision has not been made yet. MP

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*All plans will be finalized prior to sign-off on client requirements documentation.
 ** May be implemented in a second phase
 *** Carrier file only

3 IMPLEMENTATION SERVICES

The Choicelinx implementation process is outlined below.

A Choicelinx specialist will guide the Client through each phase of the implementation.



Standard Implementation



3.1 Project Kick-Off

Upon commencement of the project, Choicelinx will hold an initial kick-off session. During this session, Choicelinx will:

- Introduce the project team
- Review the implementation process and calendar
- Reach mutual agreement on the overall project timeline and dates
- Review high level benefit and file requirements

Upon completion of the kick-off, an implementation calendar will be provided that outlines all agreed upon dates and key implementation activities.

3.2 Requirements Gathering

A specialist will lead the Client through the requirements gathering process; this will include gathering data such as:

- Contribution classes
- Eligibility group information
- Carrier Information
- Client/Vendor specific forms such as benefit summaries

It is during this time that Client benefits and business rules for Annual Enrollment and New Hire enrollments will be gathered. If any requirements are identified that may be outside of the product's capabilities, the Choicelinx specialist will work with the Client to determine how the client's needs will be served within the configuration parameters of the Benefits InsightSM solution. Upon completion of requirements gathering, the Client will be provided with the relevant documentation to review and approve. Configuration begins upon sign-off of the requirements. Any changes after sign-off of the requirements may require a change request.

3.3 Configuration

Choicelinx will configure the application in accordance with the approved requirements. Choicelinx uses a variety of testing procedures both automated and manual to determine that the software is configured appropriately. Test plans will be created to test benefit configurations, content, and other configured data to ensure quality. These test plans are made available for Client testing during the acceptance phase.



3.4 Data Integration

Data integration includes the services required to load employee demographic and indicative data necessary to determine benefit eligibility and enforce the desired business rules. This is referred to as the “employee roster”. Choicelinx will provide a recommended format for this data.

If a “passive” open enrollment is required, data integration will also include obtaining current employee and dependent benefit election data to load into the online enrollment platform. This is referred to as the “election data”. As with the “employee roster”, Choicelinx will provide a recommended format for this data.

This statement of services includes up to 40 hours of labor and support to assist with mapping the supplied “employee roster” data and to assist with loading “benefit election” (for passive enrollment clients) data to the online enrollment platform. While a recommended format is provided, Choicelinx realizes that data cannot always be provided in that format. Choicelinx will do their best to accommodate data in the format most convenient for the Client however in some cases; additional services may be required to perform this activity. Your Choicelinx specialist will guide the Client through the process and inform you if a change request is necessary to perform any additional mapping and/or data services.

3.5 Training and Customer Acceptance

Once configuration and data integration are complete, Choicelinx will provide training services for up to 5 people via an online session. Training will take approximately 3 hours and will cover the most common uses of the online enrollment platform. Additional training is provided throughout the year for newly hired administrators.

Once training is complete, access to a testing platform will be provided. This testing environment will be configured as described in the requirements documentation and loaded with the data supplied during data integration. We will make the test site available for Client to perform any desired testing to ensure the system is working as desired. Issues reported during acceptance testing will be triaged addressed with an action plan.

3.6 Transition to Production

Once all testing is complete, Choicelinx will configure the production environment for use. A final load of employee data and elections is performed and the system is validated to ensure proper operation.

3.7 Client Obligation

Client will assign a key point of contact during implementation that will be tasked with participating in the critical requirements gathering phase and provide Choicelinx with Client’s business rules as they relate to eligibility and reporting. Client will be required to sign off on the Client requirements document and participate and sign-off on Client Acceptance Testing prior to a production release.

This statement of services assumes requirements gathering, review, and Client sign-off will be completed within a reasonable timely manner. If requirements gathering cannot be completed in time, the Choicelinx specialist will walk the Client through the available options based on your unique situation and project timeline. This may include a delay in the schedule and/or a change request to adjust project resources to account for delays and maintain project schedule.

4 STANDARD ONGOING SERVICES

This section describes the standard ongoing services that are included.



4.1 Online Enrollment Support (Administrators)

Online enrollment support is provided for the Client's benefits administrators for help using the enrollment platform. This includes items such as navigation, how to access reports, how to update benefits for an employee. Support is provided to benefit administrators who have attended training. Online training for newly hired staff is included in our standard service offering.

Access to standard technical support is provided during Choicelinx non-holiday weekdays from 8:30AM EST to 5:00 PM EST. An escalation process for emergency support issues outside of standard business hours will be outlined during implementation.

4.2 Online Enrollment Support (Employees)

The Choicelinx Call Center is offered for the full benefit year and provides a toll free number and representatives who are trained to answer most callers questions, including general information questions, password reset and other technical questions and, most importantly, to help them enroll using the Benefits InsightSM system that allows the Call Center Representative to enroll on behalf of the employee.

Call Center Details

Types of calls handled:

- General benefits questions
- Technical support
- Enrollment support for all benefits types

Hours of Operation and Phone Number:

- Monday – Friday; 8 am – 8 pm EST
- 855-246-1872

Language Capabilities:

- Multi-lingual , Spanish speakers on-site
- Other languages will be supported using "The Language Line" – a professional translation service

4.3 Vendor Files / Feeds

Choicelinx will transmit data to Cigna two times per week or less frequently if desired by the client. Client will be responsible for transmitting data to all additional third party vendors, unless additional non-Cigna file feeds are agreed-upon (see addendum).

Emergency eligibility updates that are required outside of the vendor file/feed schedule (for example, an immediate access to care change) are the responsibility of the Client and the associated vendor. Benefits InsightSM should be updated with any eligibility changes made directly with the vendor.

4.4 Ongoing "Employee Data" Feed

Choicelinx will accept a weekly feed of new hires, terminations, newly eligible employees; payroll group changes and ongoing payroll changes (not benefit election data). This feed's requirements will be determined and tested during the data integration phase of the implementation.

This statement of services includes up to 5 hours of labor and support to assist with mapping the supplied "employee data" to the online enrollment platform. While a recommended format is provided, Choicelinx realizes that data cannot always be provided in that format. Choicelinx will do their best to accommodate data in the format most convenient for the Client however in some cases; additional services may be required to perform this activity. Your Choicelinx specialist will guide the Client through the process and inform you if a change request is necessary to perform any additional mapping and/or data services.



5 NON-STANDARD SERVICES AND REPORTING

After initial implementation, changes to the enrollment platform configuration or adhoc reports will require a change request. Upon receipt of a change request, Choicelinx will assess the work effort and define an implementation timeline. Items that would require a change request outside of implementation and renewal include modification to previously agreed upon configuration information as documented in the requirements gathering documentation. Fees may apply. See Section 6.

Examples may include, but not limited to:

- Switching from Cigna to a non-Cigna carrier outside of Annual Enrollment
- Addition of new EOI rules outside of Annual Enrollment
- Addition of new payroll codes, contribution classes or eligibility group changes outside of Annual enrollment
- Custom reports

The online enrollment platform provides access to a variety of self-service reports including a standard payroll deduction file. These reports can be accessed on an as needed basis from the online benefits administration platform.

6 CHANGE REQUESTS

When a change request is made, Choicelinx will document the change, the cost impact (if applicable), and the schedule impact (if applicable). This documentation will be provided to the Client for review and approval. All change requests agreed to between Choicelinx and Client in writing are billed on a time and materials basis at \$150/hr. Fees are billable upon execution of the change order form.

7 PLATFORM FEES AND ELIGIBILITY FILES

The platform portion of the expense is waived when the client has Cigna Medical and/or Cigna Group/Voluntary Products.

Benefits Insight Pricing is based on the employer size in total employees and the number of non-Cigna carriers for which we manage electronic data exchange (EDI).

Platform fees, if applicable, will be invoiced as execution of the Statement of Services. Costs for non-Cigna carrier feeds will be invoiced upon completion of Implementation.

Annual Fees	Platform/File Fees	
Client Information		
Number of employees	1000-2999	\$48,000.00
Cigna products to waive platform fee		-\$48,000.00
Total Platform Fee		\$0.00
Non-Cigna Files Needed		\$8,500.00 (1)
		\$17,000.00 (2)
		\$25,500.00 (3)
		\$34,000.00 (4+)
Total Annual Fee	Based on number of files needed	



STATEMENT OF SERVICES

Service Summary	
Initial Implementation	Included
Initial Data Imports	Included
Administrator Training	Included
Secure Web Platform	Included
Electronic Data Interchange with Cigna	Included
Ongoing Services	
Enrollment & Eligibility Management	Included
Administrator and Employee Self-Service	Included
Standard and Custom (Ad Hoc) Reports	Included
Electronic Data Interchange with Non-Cigna Carriers	Based on number of files needed
Call Center Support	Included with CGI Benefits
Site Maintenance	Included

8 SIGNATURES

Upon execution of this statement of services, project work will be initiated, and the Client will be contacted by our professional services staff to begin project work. This SOS is intended to supplement the Choicelinx License & Service Agreement and the Administrative Services Only Agreement (ASO Agreement) and/or the Policy of Insurance between Client and Cigna Health and Life Insurance Company and Life Insurance Company of North America (“Cigna”). This SOS will remain in effect until the termination of the ASO Agreement or Policy of Insurance, unless mutually agreed upon by the parties. In the event that Client elects to continue with Choicelinx services without a Cigna ASO Agreement or Policy of Insurance contract, the Client will be required to sign a new Choicelinx License & Service Agreement (LSA) and a new SOS will be executed to reflect the applicable fees.

Client agrees to the services described in this statement of services. Any service not explicitly outlined in this document is considered out of scope and shall be set forth in a change order request.

Upon completion of this document, please fax the document to Choicelinx at 603.314.6001.

Sales Representative Name: _____
(Please Print)

Signature: _____ Date: _____

Client/Client Representative: _____
(Please Print)

Signature: _____ Date: _____



STATEMENT OF SERVICES

ATTEST:

YOLANDA Y. VIGIL, CITY CLERK

APPROVED AS TO FORM:

[Handwritten Signature] 4/23/15

KELLEY A. BRENNAN, CITY ATTORNEY

APPROVED:

OSCAR RODRIGUEZ, FINANCE
DIRECTOR

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