2020 MASTER PURCHASE AGREEMENT

UNITED HEALTHCARE SERVICES, INC.
AND
UNITEDHEALTHCARE INSURANCE COMPANY

THIS MASTER PURCHASE AGREEMENT (referred to herein as the "Agreement") is made between the **CITY AND COUNTY OF DENVER**, a municipal corporation of the State of Colorado (the "City") and United HealthCare Services, Inc. 185 Asylum Street, Hartford, CT 06103-0450 "**Claims Administrator,**" and UnitedHealthcare Insurance Company, 185 Asylum Street, Hartford, CT 06103-0450 (the "**Insurance Company,**") and jointly "the parties").

RECITALS

WHEREAS, for the first time, the City intends to purchase services for use with City's Self-Funded high deductible health plan as of January 1, 2020 through Claims Administrator.

WHEREAS, the City also intends to purchase services for use with City's Self-Funded deductible co-insurance benefits plan.

WHEREAS, part of the health plan programs intended includes a stop loss insurance policy.

WHEREAS, the current exhibits are intended to evidence the party's intent for stop loss insurance coverage and administration of the Self-Funded high deductible health benefits plan.

NOW, THEREFORE, in consideration of the foregoing Recitals and the mutual promises and covenants hereinafter set forth, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

1. **DEFINITIONS**: When terms are capitalized in the Agreement they have the meanings set forth in the Agreement or the Self-Funded Benefits Plan Administrative Services Agreement ("ASA"), attached hereto. The Insurance Company shall fully coordinate the purchase of agreed stop loss policies and the Claims Administrator shall fully coordinate the purchase of agreed services with the Executive Director of the Office of Human Resources or the Executive Director's designee ("**Executive Director**").

2. The Executive Director shall be the authorized representative to sign the attached exhibits, and any other documents necessary to implement the agreed insurance plans and

services the City desires to purchase through this Agreement.

3. The Executive Director's signature authority shall be limited and in no way increase or expand the City's potential or express liability or obligations beyond those liabilities and obligations stated in this Agreement.

4. SERVICES TO BE PERFORMED:

a. The claims administration services being purchased by the City requires approval by the City Board of Trustees. The documents attached in Exhibit A are intended to evidence and put in place the Self-Funded claims processing and related service arrangements and administration for both the City's self-funded Plan known as the "Choice Plus HSA" and the "Doctor's Plan Choice" ("**Exhibit A**").

b. If required, Exhibit A-4 is authorized to be signed to the extent it is required of a governmental self-insured plan and to the extent that the City has covered lives in the State of New York only.

c. If the finalized Self-Funded Summary Plan Description and the SPD is not finalized sufficiently in advance of the Effective Date of United's services, Claims Administrator will either (i) utilize the summary of Plan benefits and exclusions that United has created based on its understanding of City's Plan design and which City has reviewed and approved or (ii) create, at Claims Administrator's discretion, an operational SPD which will be based upon the summary of Plan benefits that Customer has reviewed and approved. Claims Administrator will administer claims and otherwise provide its services in accordance with this summary of Plan benefits and exclusions or operational SPD, as the case may be, and it will govern and remain in full force and effect until a final SPD is provided to Claims Administrator.

d. This Agreement replaces any prior written or oral communications or agreements between the parties relating to the subject matter of this Agreement.

5. TERM: This Agreement be effective January 1, 2020 ("Effective Date") and will expire at 11:59 p.m. on December 31, 2022 (the "Initial Term"). Unless the Self-Funded Benefits Plan Administrative Services Agreement is terminated earlier in accordance with the terms of Exhibit A-1, or the parties sign an amendment to extend this Master Purchase Agreement, in which event will concurrently expressly extend the Self-Funded Benefits Plan Administrative Services Agreement for the successive term.

6. The underlying stop loss insurance policies shall be effective January 1, 2020 ("Effective Date") and will expire at 11:59 p.m. on December 31, 2020 (the "Stop Loss Term"). The stop loss insurance policies shall be renewed annually, with a provider chosen by the City.

7. COMPENSATION AND PAYMENT:

a. Fee: The City shall pay, and the Insurance Company and Claims Administrator shall accept as the compensation, amounts that do not exceed the Maximum Contract Amount, as required in the stop loss policies attached in Exhibit A-3, as payment for the stop loss policy and services.

Notwithstanding any other provision, if the Self-Funded Benefits Plan Administrative Services Agreement is terminated by the City prior to the end of the Initial Term (defined therein), the City shall be responsible to pay all pro rata amounts due through the end of the calendar month of termination, and any other repayment of penalties for termination prior to the end of the "Initial Term" may apply, as identified in Exhibit A-1.

Notwithstanding any other provision, if a policy is cancelled by the City prior to the end of the Term, the City shall be responsible to pay all pro rata amounts due through the end of the calendar month of termination.

b. Reimbursable Expenses: There are no reimbursable expenses allowed under the policy. Notwithstanding any term in the policy to the contrary and outside of the policy premium costs, the Insurance Company will not collect or attempt to collect any direct cost associated with the policies purchased by the City. Further, the Insurance Company agrees not to adjust the policy premiums at any time prior to the expiration of the Stop Loss term.

c. Maximum Contract Amount:

(1) Notwithstanding any other provision of the Agreement, the City's maximum payment obligation to Insurance Company and Claims Administrator shall not exceed **EIGHTY MILLION AND 00/100 DOLLARS ($80,000,000.00**), (the "**Maximum Contract Amount**") for the policies, and administration services listed in Exhibit A. The City is not obligated to execute an Agreement or any amendments for any further services, including any services performed by Insurance Company or Claims Administrator beyond that specifically described in Exhibit A. Any services performed beyond those in Exhibit A are performed at Insurance

Company and Claims Administrator's risk and without authorization under this Agreement.

(2) The City's payment obligation, whether direct or contingent, extends only to funds appropriated annually by the Denver City Council, paid into the Treasury of the City, and encumbered for the purpose of the Agreement. The City does not by this Agreement irrevocably pledge present cash reserves for payment or performance in future fiscal years. The Agreement does not and is not intended to create a multiple-fiscal year direct or indirect debt or financial obligation of the City.

8. STATUS OF INSURANCE COMPANY AND CLAIMS ADMINISTRATOR: The Insurance Company and Claims Administrator are each an independent contractor. Neither the Insurance Company nor Claims Administrator nor any of its employees are employees or officers of the City under Chapter 18 of the Denver Revised Municipal Code, or for any purpose whatsoever.

9. TERMINATION:

a. The City has the right to terminate any Self-Funded arrangement listed in Exhibit A, with or without cause upon thirty (30) days prior written notice to the Claims Administrator, or otherwise under the terms of the Self-Funded Benefits Plan Administrative Services Agreement as referenced in Exhibit A.

b. The City has the right to terminate the stop loss policy listed in Exhibit A-3, or all associated policies and arrangements, with or without cause upon sixty (60) days prior written notice to the Insurance Company or under the terms of the policies as referenced in Exhibit A-3.

c. Upon termination the Claims Administrator shall have no claim against the City by reason of, or arising out of, incidental or relating to termination, except for compensation, claims funding or reimbursement due under the Self-Funded Benefits Plan Administrative Services Agreement, for services rendered prior termination, and the Insurance Company shall have no claim against the City by reason of, or arising out of, incidental or relating to termination, except for compensation due under a policy for the month of termination.

10. EXAMINATION OF RECORDS: Any authorized agent of the City, including the City Auditor or his or her representative, has the right to reasonable access and the right to examine pertinent books, documents, papers and records of the Claims Administrator and Insurance Company, involving transactions related to the Agreement, Nothing in this provision

shall require the Insurance Company or Claims Administrator to make disclosures in violation of state or federal privacy laws.

11. WHEN RIGHTS AND REMEDIES NOT WAIVED: In no event will any payment or other action by a party constitute or be construed to be a waiver by the other party of any breach of covenant or default that may then exist on the part of the other party. No payment, other action, or inaction by a party when any breach or default exists will impair or prejudice any right or remedy available to it with respect to any breach or default. No assent, expressed or implied, to any breach of any term of the Agreement constitutes a waiver of any other breach.

12. INSURANCE:

a. General Conditions: Insurance Company and Claims Administrator agree to secure, at or before the time of execution of this Agreement, the following insurance covering all operations, goods or services provided pursuant to this Agreement. Insurance Company and Claims Administrator shall always keep the required insurance coverage in force during the term of the Agreement, or any extension thereof, during any warranty period, and for three (3) years after termination of the Agreement. The required insurance shall be underwritten by an insurer licensed or authorized to do business in Colorado and rated by A.M. Best Company as "A-"VIII or better. Each policy shall contain a valid provision or endorsement requiring notification to the City in the event any of the above- described policies are canceled before the expiration date thereof. Such written notice shall be sent to the parties identified in the Notices section of this Agreement and shall reference the City contract number listed on the signature page of this Agreement. Said notice shall be sent thirty (30) days prior to such cancellation unless due to non- payment of premiums for which notice shall be sent ten (10) days prior. If such written notice is unavailable from the insurer, Insurance Company and Claims Administrator shall provide written notice of cancellation, non-renewal and any reduction in coverage to the parties identified in the Notices section within three (3) business days of such notice by its insurer(s) and referencing the City's contract number. Insurance Company and Claims Administrator shall be responsible for the payment of any deductible or self-insured retention. The insurance coverages specified in this Agreement are the minimum requirements, and these requirements do not lessen or limit the liability of the Insurance Company and Claims Administrator. The Insurance Company and Claims Administrator shall maintain, at its own

expense, any additional kinds or amounts of insurance that it may deem necessary to cover its obligations and liabilities under this Agreement.

b. Proof of Insurance: Insurance Company and Claims Administrator may not commence services or work relating to the Agreement prior to placement of coverages required under this Agreement. Consultant certifies and warrants that if no certificate of insurance is provided, preferably an ACORD certificate, the Consultant will either maintain minimum insurances that comply with all insurance requirements of this Agreement or will self-insure each required minimum coverage. The City requests that the City's contract number be referenced on the Certificate. The City's acceptance of a certificate of insurance or other proof of insurance that does not comply with all insurance requirements set forth in this Agreement shall not act as a waiver of Insurance Company and Claims Administrator's breach of this Agreement or of any of the City's rights or remedies under this Agreement.

c. Waiver of Subrogation: For all coverages, except the professional, cyber liability, and technology E&O, Insurance Company and Claims Administrator's insurer shall waive subrogation rights against the City.

d. Workers' Compensation/Employer's Liability Insurance: Insurance Company and Claims Administrator shall maintain the coverage as required by statute for each work location and shall maintain Employer's Liability insurance with limits of $100,000 per occurrence for each bodily injury claim, $100,000 per occurrence for each bodily injury caused by disease claim, and $500,000 aggregate for all bodily injuries caused by disease claims. Insurance Company and Claims Administrator expressly represents to the City, as a material representation upon which the City is relying in entering into this Agreement, that none of the Insurance Company's and Claims Administrator's officers or employees who may be eligible under any statute or law to reject Workers' Compensation Insurance shall effect such rejection during any part of the term of this Agreement, and that any such rejections previously effected, have been revoked as of the date Insurance Company executes this Agreement.

e. Commercial General Liability: Insurance Company and Claims Administrator shall maintain a Commercial General Liability insurance policy with limits of $1,000,000 for each occurrence, $1,000,000 for each personal and advertising injury claim, $2,000,000 products and completed operations aggregate, and $2,000,000 policy aggregate.

f. **Business Automobile Liability**: Insurance Company and Claims Administrator shall maintain Business Automobile Liability with limits of $1,000,000 combined single limit applicable to all owned, hired and non-owned vehicles used in performing services under this Agreement.

g. **Professional Liability (Errors & Omissions)**: Insurance Company and Claims Administrator shall maintain limits of $1,000,000 per claim and $1,000,000 policy aggregate limit.

h. **Cyber Liability:** Contractor shall maintain Cyber Liability coverage with limits of $1,000,000 per claim and $1,000,000 policy aggregate covering third party claims involving privacy violations, information theft, and intentional and/or unintentional release of private information.

13. DEFENSE AND INDEMNIFICATION

a. To the fullest extent permitted by law, Insurance Company and Claims Administrator hereby agree to defend, indemnify, reimburse and hold harmless City, its appointed and elected officials, agents and employees for, from and against all liabilities, claims, judgments, suits or demands for damages to persons or property arising out of, resulting from, or related to the work performed under this Agreement by a third party ("Claims"), unless such Claims have been specifically determined by the trier of fact to be the sole negligence or willful misconduct of the City. This indemnity shall be interpreted in the broadest possible manner to indemnify City for any acts or omissions of Insurance Company or its subcontractors either passive or active, irrespective of fault, including City's concurrent negligence whether active or passive, except for the sole negligence or willful misconduct of City.

As applicable to the Self-Funded Benefits Plan Administrative Services Agreement, City will remain responsible for payment of benefits and United's indemnification will not extend to the City's management of the Self-funded Plan against any claims, liabilities, damages, judgments, or expenses that constitute payment of Plan benefits.

b. Insurance Company's and Claims Administrator's duty to defend and indemnify City shall arise at the time written notice of the Claim is first provided to City regardless of whether suit has been filed and even if Insurance Company or Claims Administrator is not named as a Defendant. Insurance Company's and Claims Administrator's

duty to defend and indemnify City shall arise even if City is the only party sued by claimant and/or claimant alleges that City's negligence or willful misconduct was the sole cause of claimant's damages.

c. Insurance Company and/or Claims Administrator will defend any and all Claims which may be brought or threatened against City and will pay on behalf of City any expenses incurred by reason of such Claims including, but not limited to, court costs and attorney fees incurred in defending and investigating such Claims or seeking to enforce this indemnity obligation. Such payments on behalf of City shall be in addition to any other legal remedies available to City and shall not be considered City's exclusive remedy.

d. Insurance coverage requirements specified in this Agreement shall in no way lessen or limit the liability of the Insurance Company or Claims Administrator under the terms of this indemnification obligation. Insurance Company and Claims Administrator shall obtain, at its own expense, any additional insurance that it deems necessary for the City's protection.

e. This defense and indemnification obligation shall survive the expiration or termination of this Agreement.

14. TAXES, CHARGES AND PENALTIES: As applicable to the stop loss policy, and subject to limitations in the Self-Funded Benefits Plan Administrative Services Agreement, the City is not liable for the payment of taxes, late charges or penalties of any nature, except for any additional amounts that the City may be required to pay under the City's prompt payment ordinance D.R.M.C. § 20-107, *et seq*. The Insurance Company shall promptly pay when due, all taxes, bills, debts and obligations it incurs performing the services under the Agreement and shall not allow any lien, mortgage, judgment or execution to be filed against City property.

15. ASSIGNMENT; SUBCONTRACTING: To the extent necessary to provide products and services contemplated in this document, the Parties agree United will use subcontractors to provide the services and benefits contemplated for purchase herein. United will be responsible for those services to the same extent that United would have been had it performed those services without the use of an affiliate or subcontractor. Insurance Company and/or Claims Administrator can assign this Agreement, including its rights and obligations to Insurance Company's and/or Claims Administrator's affiliates, to an entity controlling, controlled by, or under common control with Insurance Company and/or Claims Administrator,

or a purchase of all or substantially all of Insurance Company's and/or Claims Administrator's assets, subject to notice to the City of the assignments. In the event of any unauthorized assignment: (i) the Insurance Company and/or Claims Administrator shall remain responsible to the City; and (ii) no contractual relationship shall be created between the City and any sub-Insurance Company or sub-Claims Administrator assign.

16. INUREMENT: The rights and obligations of the parties to the Agreement inure to the benefit of and shall be binding upon the parties and their respective successors and assigns, provided assignments are consented to in accordance with the terms of the Agreement.

17. NO THIRD PARTY BENEFICIARY: Enforcement of the terms of the Agreement and all rights of action relating to enforcement are strictly reserved to the parties. Nothing contained in the Agreement gives or allows any claim or right of action to any third person or entity. Any person or entity other than the City or the Insurance Company or Claims Administrator receiving services or benefits pursuant to the Agreement is an incidental beneficiary only.

18. GRANT OF LIMITED LICENSE TO USE LOGO

a. City hereby grants to Consultant, subject to the terms and conditions set forth herein, a non-exclusive, nontransferable limited license, to use the "Denver D" logo ("**Denver Logo**") during the Term of this Agreement.

b. Insurance Company and Claims Administrator shall fully coordinate all logo use under this Agreement with the Denver Marketing Office (www.denvergov.org/brandcenter, (720) 865-2300, marketing@denvergov.org), or otherwise as directed by the City.

a. The use of the Denver Logo is limited to display on the website to be created by Claims Administrator pursuant to this Agreement and for identification only. Claims Administrator shall display the Denver Logo in a read-only format and shall not be used or displayed on the website in any format from which it can be downloaded, copied or reproduced in any manner.

b. The license granted by the City is non-transferable and non-assignable to anyone other than those acting under the supervision and authority of Insurance Company or Claims Administrator.

c. Claims Administrator shall be solely responsible for the entire cost and expense of Claims Administrator's Use of the Denver Logo on standard ID cards, SBCs and Summary Plan Descriptions.

d. The Denver Logo may not be used as a feature or design element of any other logo or graphic.

e. Insurance Company and Claims Administrator shall affix a trademark ("™") or registration ("®") indication next to the Denver Logo as directed by the Denver Marketing Office.

f. Insurance Company and Claims Administrator shall immediately cease all further use of the Denver Logo upon expiration of the Term of this Agreement, as may have been extended from time to time by the parties, in a formal written extension of this agreement.

19. NO AUTHORITY TO BIND CITY TO CONTRACTS: The Insurance Company and Claims Administrator lack any authority to bind the City on any contractual matters. Final approval of all contractual matters that purport to obligate the City must be executed by the City in accordance with the City's Charter and the Denver Revised Municipal Code.

20. SEVERABILITY: Except for the provisions of the Agreement requiring appropriation of funds and limiting the total amount payable by the City, if a court of competent jurisdiction finds any provision of the Agreement or any portion of it to be invalid, illegal, or unenforceable, the validity of the remaining portions or provisions will not be affected, if the intent of the parties can be fulfilled.

21. CONFLICT OF INTEREST:

a. No employee of the City shall have any personal or beneficial interest in the services or property described in the Agreement, except as a Plan Participant. The Insurance Company and Claims Administrator shall not hire, or contract for services with, any employee or officer of the City that would be in violation of the City's Code of Ethics, D.R.M.C. §2-51, et seq. or the Charter §§ 1.2.8, 1.2.9, and 1.2.12. Employees are prohibited from being used in any promotional video or photos for any reason without the written permission of the Denver City Attorney's office.

b. The Insurance Company and Claims Administrator shall not engage in any transaction, activity or conduct that would result in a conflict of interest under the Agreement.

The Insurance Company and Claims Administrator represents that it has disclosed any and all current or potential conflicts of interest. A conflict of interest shall include transactions, activities or conduct that would affect the judgment, actions or work of the Insurance Company or Claims Administrator by placing the Insurance Company's or Claims Administrator's own interests, or the interests of any party with whom the Insurance Company or Claims Administrator has a contractual arrangement, in conflict with those of the City. The City, in its sole discretion, will determine the existence of a conflict of interest and may terminate the Agreement if it determines a conflict exists, after it has given the Insurance Company or Claims Administrator written notice describing the conflict.

22. **NOTICES**: Policy restrictions notwithstanding, all notices required by the terms of the Agreement must be hand delivered, sent by overnight courier service, mailed by certified mail, return receipt requested, or mailed via United States mail, postage prepaid, if to Insurance Company or Claims Administrator at the address first above written, and if to the City at:

If to the Claims Administrator:

Jennifer Behm
Account Vice President
UnitedHealth Group
6465 Greenwood Plaza Blvd, Suite 300
Centennial CO 80111

With a copy of any such notice to:

Dean Dastvar
Associate General Counsel
UnitedHealthcare
12018 Sunrise Valley Drive, Suite 400
Reston, VA 20191

If to the City:

Executive Director
Office Human Resources
201 West Colfax Avenue, Dept. 412
Denver, Colorado 80202

With a copy of any such notice to:

Denver City Attorney's Office
Municipal Operations - Benefits Counsel
1437 Bannock St., Room 353
Denver, Colorado 80202

Notices hand delivered or sent by overnight courier are effective upon delivery. Notices sent by certified mail are effective upon receipt. Notices sent by mail are effective upon deposit with the U.S. Postal Service. The parties may designate substitute addresses where or persons to whom notices are to be mailed or delivered. However, these substitutions will not become effective until actual receipt of written notification.

23. NO EMPLOYMENT OF ILLEGAL ALIENS TO PERFORM WORK UNDER THE AGREEMENT:

a. This Agreement is subject to Division 5 of Article IV of Chapter 20 of the Denver Revised Municipal Code, and any amendments (the "Certification Ordinance").

b. The Insurance Company and Claims Administrator certify that:

(1) At the time of its execution of this Agreement, it does not knowingly employ or contract with an illegal alien who will perform work under this Agreement.

(2) It will participate in the E-Verify Program, as defined in § 8-17.5-101(3.7), C.R.S., to confirm the employment eligibility of all employees who are newly hired for employment to perform work under this Agreement.

c. The Insurance Company and Claims Administrator also agree and represents that:

(1) It shall not knowingly employ or contract with an illegal alien to perform work under the Agreement.

(2) It shall not enter into a contract with a subconsultant or subcontractor that fails to certify to the Insurance Company or Claims Administrator that it shall not knowingly

employ or contract with an illegal alien to perform work under the Agreement.

(3) It has confirmed the employment eligibility of all employees who are newly hired for employment to perform work under this Agreement, through participation in either the E-Verify Program.

(4) It is prohibited from using either the E-Verify Program procedures to undertake pre-employment screening of job applicants while those applicants are performing its obligations under the Agreement, and it is required to comply with any and all federal requirements related to use of the E-Verify Program including, by way of example, all program requirements related to employee notification and preservation of employee rights.

(5) If it obtains actual knowledge that a subconsultant or subcontractor performing work under the Agreement knowingly employs or contracts with an illegal alien, it will notify such subconsultant or subcontractor and the City within three (3) days. The Insurance Company and Claims Administrator shall also terminate such subconsultant or subcontractor from any performance under this Agreement if within three (3) days after such notice the subconsultant or subcontractor does not stop employing or contracting with the illegal alien, unless during such three-day period the subconsultant or subcontractor provides information to establish that the subconsultant or subcontractor has not knowingly employed or contracted with an illegal alien.

(6) It will comply with any reasonable request made in the course of an investigation by the Colorado Department of Labor and Employment under authority of § 8-17.5-102(5), C.R.S., or the City Auditor, under authority of D.R.M.C. 20-90.3.

d. The Insurance Company and Claims Administrator are each individually liable for any violations as provided in the Certification Ordinance. If Insurance Company or Claims Administrator violates any provision of this section or the Certification Ordinance, the City may terminate this Agreement for a breach of the Agreement. If the Agreement is so terminated, the Insurance Company or Claims Administrator shall be liable for actual damages to the City. Any such termination of a contract due to a violation of this section or the Certification Ordinance may also, at the discretion of the City, constitute grounds for disqualifying Insurance Company or Claims Administrator from submitting bids or proposals for future contracts with the City.

24. DISPUTES. In the event of dispute, the complaining party will notify the other

party in writing. The parties will both make efforts to resolve the complaint. If the complaint is not resolved within 30 days of the notice of complaint, the complaining party is free to begin litigation of the issue in any appropriate venue.

25. GOVERNING LAW; VENUE: The Agreement will be construed and enforced in accordance with applicable federal law, the laws of the State of Colorado, and the applicable Charter, Revised Municipal Code, ordinances, regulations and Executive Orders of the City and County of Denver, which are expressly incorporated into the Agreement. Unless otherwise specified, any reference to statutes, laws, regulations, charter or code provisions, ordinances, executive orders, or related memoranda, includes amendments or supplements to same. Venue for any legal action relating to the Agreement will be in the District Court of the State of Colorado, Second Judicial District (Denver District Court).

26. NO DISCRIMINATION IN EMPLOYMENT: In connection with the performance of work under the Agreement, the Insurance Company and Claims Administrator may not refuse to hire, discharge, promote or demote, or discriminate in matters of compensation against any person otherwise qualified, solely because of race, color, religion, national origin, gender, age, military status, sexual orientation, gender identity or gender expression, marital status, or physical or mental disability. The Insurance Company and Claims Administrator shall insert similar foregoing provision in all subcontracts.

27. COMPLIANCE WITH ALL LAWS: Each party shall perform or cause to be performed all services and obligations, both in this Agreement and pursuant to any insurance policies or claims administration services referenced in Exhibit A, in full compliance with all applicable laws, rules, regulations and codes of the United States, the State of Colorado; and with the applicable Charter, ordinances, rules, regulations and Executive Orders of the City and County of Denver.

28. LEGAL AUTHORITY: Insurance Company and Claims Administrator each represents and warrants that it possesses the legal authority, pursuant to any proper, appropriate and official motion, resolution or action passed or taken, to enter into the Agreement. Each person signing and executing the Agreement on behalf of Insurance Company and Claims Administrator represents and warrants that he has been fully authorized by Insurance Company and Claims Administrator to execute the Agreement on behalf of Insurance Company and Claims Administrator and to validly and legally bind Insurance Company and Claims

Administrator to all the terms, performances and provisions of the Agreement. The City shall have the right, in its sole discretion, to either temporarily suspend or permanently terminate the Agreement if there is a reasonable dispute as to the legal authority of either Insurance Company and Claims Administrator or the person signing the Agreement to enter into the Agreement.

29. NO CONSTRUCTION AGAINST DRAFTING PARTY: The parties and their respective counsel have had the opportunity to review the Agreement, and the Agreement will not be construed against any party merely because any provisions of the Agreement were prepared by a party.

30. ORDER OF PRECEDENCE: In the event of any conflicts between the language of the Agreement and any of the exhibits, the language of the Agreement controls, unless such language of the Agreement is severed because it was held to be invalid, illegal, or unenforceable in any respect.

31. SURVIVAL OF CERTAIN PROVISIONS: The terms of the Agreement and any exhibits and attachments that by reasonable implication contemplate continued performance, rights, or compliance beyond expiration or termination of the Agreement survive the Agreement and will continue to be enforceable. Without limiting the generality of this provision, the Insurance Company's obligations to provide insurance and Insurance Company and Claims Administrator obligations to indemnify the City will survive for a period equal to any and all relevant statutes of limitation, plus the time necessary to fully resolve any claims, matters, or actions begun within that period.

32. ADVERTISING AND PUBLIC DISCLOSURE: The Insurance Company and Claims Administrator shall not include any reference to the Agreement or to services performed pursuant to the Agreement in any of the Insurance Company's and Claims Administrator's advertising or public relations materials without first obtaining the written approval of the Executive Director. Any oral presentation or written materials related to services performed under the Agreement will be limited to services that have been accepted by the City. The Insurance Company and Claims Administrator shall notify the Executive Director in advance of the date and time of any presentation. Nothing in this provision precludes the transmittal of any information to City officials.

33. CONFIDENTIAL INFORMATION:

a. City Information: Each party acknowledges and accepts that, in performance of all work under the terms of this Agreement, the other party may have access to Proprietary Data or confidential information that may be owned or controlled by the other party, and that the disclosure of such Proprietary Data or information may be damaging to the other party or third parties. Each party agrees that all Proprietary Data, confidential information or any other data or information provided or otherwise disclosed by the one party to the other party shall be held in confidence and used only in the performance of its obligations under this Agreement, or as otherwise allowed under an Attachment to this Agreement. Each party shall exercise the same standard of care to protect such Proprietary Data and information as a reasonably prudent that party would to protect its own proprietary or confidential data. "Proprietary Data" shall mean any materials or information which may be designated or marked "Proprietary" or "Confidential", or which would not be documents subject to disclosure pursuant to the Colorado Open Records Act or City ordinance, and provided or made available to one party by the other party. Such Proprietary Data may be in hardcopy, printed, digital or electronic format.

34. CITY EXECUTION OF AGREEMENT: The Agreement will not be effective or binding on the City until it has been fully executed by all required signatories of the City and County of Denver, and if required by Charter, approved by the City Council.

35. AGREEMENT AS COMPLETE INTEGRATION AMENDMENTS: The Agreement is the complete integration of all understandings between the parties as to the subject matter of the Agreement. No prior, contemporaneous or subsequent addition, deletion, or other modification has any force or effect, unless embodied in the Agreement in writing. No oral representation by any officer or employee of the City at variance with the terms of the Agreement or any written amendment to the Agreement will have any force or effect or bind the City.

36. USE, POSSESSION OR SALE OF ALCOHOL OR DRUGS: Insurance Company and Claims Administrator shall cooperate and comply with the provisions of Executive Order 94 and its Attachment A concerning the use, possession or sale of alcohol or drugs.

37. ELECTRONIC SIGNATURES AND ELECTRONIC RECORDS: Insurance Company and Claims Administrator consent to the use of electronic signatures by the City. The Agreement, and any other documents requiring a signature under the Agreement, may be signed

electronically by the City in the manner specified by the City. The parties agree not to deny the legal effect or enforceability of the Agreement solely because it is in electronic form or because an electronic record was used in its formation. The parties agree not to object to the admissibility of the Agreement in the form of an electronic record, or a paper copy of an electronic document, or a paper copy of a document bearing an electronic signature, on the ground that it is an electronic record or electronic signature or that it is not in its original form or is not an original.

[NOTE: SIGNATURE PAGES TO FOLLOW]

Contract Control Number: CSAHR-201952475-00
Contractor Name: UnitedHealthcare Insurance Company
United HealthCare Services, Inc.

IN WITNESS WHEREOF, the parties have set their hands and affixed their seals at Denver, Colorado as of:

SEAL

CITY AND COUNTY OF DENVER:

ATTEST:

By: _____

Mayor

_____

Clerk and Recorder, Ex-Officio Clerk of the City and County of Denver

APPROVED AS TO FORM:

Attorney for the City and County of Denver

By: _____

Assistant City Attorney

REGISTERED AND COUNTERSIGNED:

By: _____

Manager of Finance

By: _____

Auditor

Contract Control Number: CSAHR-201952475-00
Contractor Name: UnitedHealthcare Insurance Company

By: _____

Name: _____
(please print)

Title: _____
(please print)

ATTEST: [if required]

By: _____

Name: _____
(please print)

Title: _____
(please print)

Contract Control Number: CSAHR-201952475-00
Contractor Name: United HealthCare Services, Inc.

By: _____

Name: _____
(please print)

Title: _____
(please print)

ATTEST: [if required]

By: _____

Name: _____
(please print)

Title: _____
(please print)

EXHIBIT A
EVIDENCE OF INSURANCE PURCHASED
And
ADMINISTRATION SERVICES

1) **Exhibit A-1**: **Administrative Services Agreement** with United HealthCare Services, Inc. to act as a claims administrator for Denver's self-funded benefit plans.

2) **Exhibit A-2**: **Self-Insured demand deposit form** to be used by United HealthCare Services, Inc., as claims administrator for Denver's self-funded benefit plans, to set up a bank account from which to pay claims and costs as authorized.

3) **Exhibit A-3**: **Self-Funded** benefit plan stop loss insurance policy and application.

4) **Exhibit A-4**: New York Required Documents for Self-Funded Plan.

EXHIBIT A-1
ADMINISTRATIVE SERVICE AGREEMENT

Exhibit A-1: **Administrative Services Agreement** with United HealthCare Services, Inc. to act as a claims administrator for Denver's self-funded benefit plans.

EXHIBIT A-1 TO
MASTER PURCHASE AGREEMENT BETWEEN
UNITED HEALTHCARE SERVICES, INC. and
CITY AND COUNTY OF DENVER

SELF-FUNDED BENEFITS PLAN
ADMINISTRATIVE SERVICES AGREEMENT

This Self-Funded Benefits Plan Administrative Services Agreement ("Agreement" or "Self-Funded Benefits Plan Agreement") between United HealthCare Services, Inc. ("United" in this Agreement) and City and County of Denver ("Customer" in this Agreement) is effective January 1, 2020 ("Effective Date") and will terminate at 11:59 p.m. on December 31, 2022. This Self-Funded Benefits Plan Agreement covers the services United is providing to Customer, either directly or in conjunction with one of United's affiliates, for use with Customer's Self-Funded employee benefit plan, and is subject to the terms of the Purchase Agreement to which this Agreement is attached as Exhibit A-3 ("Master Purchase Agreement").

United HealthCare Services, Inc. identifies this arrangement as Contract No.: 717340

By signing below, each party agrees to the terms of this Agreement, subject to the terms of the Master Purchase Agreement that exists between the parties.

City and County of Denver
201 W. Colfax Dept. 412
Denver, CO 80202

United HealthCare Services, Inc.
185 Asylum Street
Hartford, CT 06103-3408

By: _____

Authorized Signature

Print Name: _____

Print Title: _____

Date: _____

By: _____

Authorized Signature

Print Name: _____

Print Title: _____

Date: _____

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Section 1 – Definitions

When these terms are capitalized in the Agreement they have the meanings set forth below. The words may be singular or plural.

Bank Account: Bank Account maintained for the payment of Plan benefits, expenses, fees and other Customer financial obligations solely for the benefit of the Customer.

Employee: A current or former employee of Customer or its affiliated employer.

IRC: The United States Internal Revenue Code of 1986, as amended from time to time.

IRS: The United States Internal Revenue Service.

Medical Benefit Drug Rebate: Any discount, price concession, or other direct or indirect remuneration United receives from a drug manufacturer under a rebate agreement that is contingent upon and related directly to Participant use of a prescription drug under the Plan's medical benefit during the Term. Medical Benefit Drug Rebate does not include any discount, price concession, administration fees, or other direct or indirect remuneration United receives from a drug manufacturer for direct purchase of a prescription drug.

Medicare Part D Retiree Drug Subsidy Program ("RDS"): The program as set forth in Section 1860D-22 of Title XVIII of the Social Security Act, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA"), Subpart R of the MMA Final Regulation, or any successor regulation promulgated by the Centers for Medicare and Medicaid Services ("CMS"), and any guidance issued by CMS, and any mandated updates of required information.

Network: The group of Network Providers United makes available to the Plan who have entered into or are governed by contractual arrangements under which they agree to provide health care services to Participants and accept negotiated fees for these services.

Network Provider: The physician, or medical professional or facility which participates in a Network. A provider is only a Network Provider if they are participating in a Network at the time services are rendered to the Plan Participant.

Overpayments: Payments that exceed the amount payable under the Plan. This term does not include overpayments caused by untimely or inaccurate eligibility information.

Participant: Employee or dependent who is covered by the Plan.

PHI: Any information United receives or provides on behalf of the Plan which is considered Protected Health Information as the term is defined in the privacy regulations of the Health Insurance Portability and Accountability Act of 1996.

Plan: The plan to which this Agreement applies, but only with respect to those provisions of the plan relating to the Self-Funded health benefits United is administering, as described in the Summary Plan Description.

Plan Administrator: The current or succeeding person, committee, partnership, or other entity designated the Plan Administrator who is generally responsible for the Plan's operation.

Proprietary Business Information: Nonpublic information, trade secrets, and other data including, but not limited to, sales and marketing information, management systems, strategic plans and other information about the disclosing party's business, industry, products and services, plans, specifications, operation methods, pricing, costs, techniques, manuals, know-how and other intellectual property, in written, oral, electronic or other tangible form, provided by one party to another or its representative; and all information, documents, technology, products, and services containing or derived from Proprietary Business Information which was or may have been transmitted, given or made available to or viewed by one party or another in the course of the party's relationship. United's Proprietary Business Information includes United Financial PBI, as defined in this Section below.

Self-Fund or **Self-Funded:** Means that Customer, on behalf of the Plan, has the sole responsibility to pay, and provide funds, to pay for all Plan benefits.

Standard of Care: In providing all services set forth in this Agreement, United shall use the care, skill, prudence and diligence under the circumstances then prevailing that a prudent claims administrator/fiduciary acting in a like capacity and familiar with such matters would use under similar circumstances.

Summary Plan Description or SPD: The document(s) Customer provides to Plan Participants describing the terms and conditions of coverage offered under the Plan.

Systems: Means the systems United owns or makes available to Customer to facilitate the transfer of information in connection with this Agreement.

Tax or **Taxes:** A charge imposed, assessed or levied by any federal, state, local or other governmental entity.

Term or Term of the Agreement: The period of twelve (12) months commencing on the Effective Date (the "Initial Term") and automatically continuing for additional 12-month periods (each, a "Renewal Term") through December 31, 2022, if the parties sign an amendment to extend the Master Purchase Agreement that will concurrently expressly extend this Self-Funded Benefits Plan Administrative Services Agreement.

United Financial PBI: United's Proprietary Business Information that includes, but is not limited to, discounts and other financial provisions related to United's contracted healthcare providers and claims data from which those financial provisions may be derived and financial provisions related to prescription drug products covered under the medical benefit, the Prescription Drug List, reimbursement rates, compensation arrangements, and all other financial provisions related to the pharmacy benefits contained in this Agreement. While the Prescription Drug List is considered United's Proprietary Business Information, it may be disclosed in the limited circumstances outlined in this Agreement.

Urgent Care Claims: A claim for medical services and supplies which meets ERISA's definition of Urgent Care Claim.

Section 2 – Customer Responsibilities

Section 2.1 Responsibility for the Plan. United is not the Plan Administrator of the Plan. Any references in this Agreement to United "administering the Plan" are descriptive only and do not confer upon United anything beyond certain agreed upon claim administration duties. Except to the extent this Agreement specifically requires United to have the fiduciary responsibility for a Plan administrative function, Customer accepts responsibility for the Plan for purposes of this Agreement, including its benefit design, the legal sufficiency and distribution of SPDs, and compliance with any laws that apply to Customer or the Plan, whether or not Customer or someone Customer designates is the Plan Administrator. The Customer represents that the Plan has the authority to pay fees due under this Agreement from Plan assets, for each annual term of the Agreement, and subject to the Maximum Contract Amounts recited in the Master Purchase Agreement between the parties.

Section 2.2 Plan Consistent with the Agreement. Customer represents that Plan documents, including the Summary Plan Description as described in Exhibit A – Statement of Work, are consistent with this Agreement. Nevertheless, before distributing any communications describing Plan benefits or provisions to Participants or third parties, Customer will provide United with such communications which refer to United or United's services. Customer will amend them if United reasonably determines that references to United are not accurate, or any Plan provision is not consistent with this Agreement or the services that United is providing.

Section 2.3 Plan Changes. Customer must provide United with notice of any changes to the Plan and/or Summary Plan Description within a reasonable period of time prior to the effective date of the change to allow United to determine if such change will alter the services United provides under this Agreement. Customer's requested changes must be mutually agreed to in writing prior to implementation of such change. United will notify Customer if (i) the change increases United's cost of providing services under this Agreement or (ii) United is reasonably unable to implement or administer the change. If the parties cannot agree to a new fee within (30) thirty days of the notice of the new fee, or if United notifies Customer that United is unable to reasonably implement or administer the change, United shall have no obligation to implement or administer the change, and Customer may terminate this Agreement upon (60) sixty days written notice.

Section 2.4 Affiliated Employers. Customer represents that together Customer and any of its affiliates covered under the Plan make up a single "controlled group" as defined the IRC. Customer agrees to provide United with a list of Customer's affiliates covered under the Plan upon request.

Section 2.5 Information Customer Provides to United. Customer will tell United which of Customer's Employees, their dependents, any other persons, or any combination of these, are Participants. This information must be accurate

and provided to United in a timely manner. United will accept eligibility data from Customer in a format that is agreed to by the parties. Customer will notify United of any change to this information as soon as reasonably possible.

United will be entitled to rely on the most current information in United's possession regarding eligibility of Participants in paying Plan benefits and providing other services under this Agreement. United will apply electronic eligibility changes without imposing any extra fees. In the event that Customer requests manual retroactive eligibility changes or retroactive eligibility changes to include claims reprocessing, United will make such changes only after the parties agree to the terms on which such changes will be made and any extra fees that would apply for doing so.

Customer agrees to provide United, in a timely manner with all information that United reasonably requires to provide services under this Agreement. United shall be entitled to rely upon any written or oral communication from Customer's designated employees, agents, or authorized representatives.

Section 2.6 Notices to Participants. Customer will give Participants the information and documents they need to obtain benefits under the Plan within a reasonable period of time before coverage begins. In the event this Agreement is discontinued, Customer will notify all Participants that the services United is providing under this Agreement are discontinued.

Section 2.7 Escheat. Customer is solely responsible for complying with all applicable abandoned property or escheat laws, making any required payments, and filing any required reports.

Section 3 – Fees

Section 3.1 Fees. Customer will pay fees to United as compensation for the services provided by United. In addition to the fees specified in Exhibit B - Fees, Customer must also pay United any additional fee that is authorized by a provision elsewhere in this Agreement or is otherwise agreed to by the parties. All fees, charges and reimbursements contemplated under this Agreement will be billed against and limited to those amounts defined in the Master Purchase Agreement as the "Maximum Contract Amount."

Section 3.2 Changes in Fees. (a) United can change the fees on each Renewal Term, subject to the provisions of Exhibit B – Fees. The parties will sign an amendment to memorialize the implementation of revised fees for subsequent Renewal Terms. Any such fee change will become effective on the later of the first day of the new Renewal Term and will be subject to the Maximum Contract Amounts recited in the Master Purchase Agreement between the parties. United will provide Customer with a new Exhibit B - Fees that will be attached to the written amendment to this Agreement.

(b) United may also initiate a fee change if any one or more of the following occur:

(1) any time there are changes made to this Agreement or the Plan, which affect the fees including the termination of the Shared Savings;

(2) when there are changes in laws or regulations which affect or are related to the services United is providing, or will be required to provide, under this Agreement, including the Taxes and fees noted in Section 5 Taxes And Assessments;

(3) if the number of Employees covered by the Plan or any Plan option changes by ten percent (10%) or more; or

(4) if the average contract size, defined as the total number of enrolled Participants divided by the total number of enrolled Employees, varies by 10% or more from the assumed average contract size set forth in Exhibit B - Fees. Any new fee required by such change will be effective as of the date the changes occur, even if that date is retroactive.

Any fee change resulting from this paragraph will be implemented by written amendment to this Agreement and be evidenced by a new Exhibit B – Fees attached thereto.

(c) If Customer does not agree to any change in fees, either party may terminate this Agreement upon thirty (30) days written notice after Customer receives written notice of the new fees. Customer must still pay any amounts due for the periods during which the Agreement is in effect.

Section 3.3 Due Dates, Payments, and Penalties. For the Standard Medical Service Fees described in Exhibit B - Fees, United will provide Customer with an on-line invoice in advance of the first of each month, typically no later

than the 18th of each month. The Due Date for payment of the invoiced amounts is on the first day of the next full calendar month ("Due Date"). Such invoices are provided on an eligibility-based format, and therefore payment must be made as billed and are subject to annual appropriations as defined in the Master Purchase Agreement (no adjustments are allowed to the invoice). If authorized by Customer pursuant to this Agreement or by subsequent authorization, certain fees will be paid through a withdrawal from the Bank Account.

Late Payment: If amounts owed are not paid within fifteen (15) days after their Due Date ("Grace Period"), Customer will pay United interest on these amounts at the interest rate that United charges to its self-funded customers. Customer agrees to reimburse United for any costs that United incurs to collect these amounts. United's decision to provide Customer with a Grace Period will be based on United's assessment of Customer's financial condition as of the Effective Date, and Customer's compliance with material financial obligations. If United determines, based on reasonable information and belief, that Customer's financial condition has deteriorated, or Customer continues to fail to comply with the material financial obligations specified in this Agreement, United may remove the Grace Period upon notice to Customer.

Section 3.4 Reconciliation. For each Renewal Term, United will reconcile the total amounts Customer paid with the total amounts Customer owed. If the reconciliation indicates that United owes Customer money, Customer's next fee invoice will be credited. If the reconciliation indicates that Customer owes United money, United will invoice Customer for the amount due. The due date for these amounts is the first day of the next calendar month. Customer will pay United, within thirty (30) days of the due date, the amounts that Customer owes United. Customer is required to pay under the City's prompt payment ordinance D.R.M.C. § 20-107, *et seq*. The interest rate United charges its self-funded customers is not to exceed the prime rate within the Agreement Period, plus 4%, and in all events any interest changes shall be in accordance with the City's prompt payment ordinance D.R.M.C. § 20-107, et seq.

If this Self-Funded Benefits Plan Agreement is terminated, United will pay Customer the amount owed within thirty (30) days after United performs a final reconciliation. If the final reconciliation indicates that Customer owes United money, Customer will pay United within the time period identified under the City's prompt payment ordinance D.R.M.C. § 20-107, et seq.

For payments Customer makes after the time period identified under the City's prompt payment ordinance D.R.M.C. § 20-107, et seq., after receiving notice of the amounts that Customer owes United, United will charge interest at the interest rate that United charge its other self-funded customers. The interest rate United charges its self-funded customers is not to exceed the prime rate within the Agreement Period, plus 4%, and in all events any interest changes shall be in accordance with the City's prompt payment ordinance D.R.M.C. § 20-107, et seq.

Section 4 – Records, Information, Audits

Section 4.1 Records. United shall keep records relating to the services it provides under this Agreement for as long as United is required to do so by law.

Section 4.2 Proprietary Business Information. Each party will limit the use of the other's Proprietary Business Information to only the information required to administer the Plan, to perform under this Agreement, or as otherwise permitted under this Agreement. Neither party will disclose the other's Proprietary Business Information to any person or entity other than to the receiving party's employees, subcontractors, or authorized agents needing access to such information to administer the Plan, to perform under this Agreement, or as otherwise permitted under this Agreement, except that United's Financial PBI cannot be disclosed by Customer to any third party without a court order or legal requirement to do so, and if permitted by law a mutually agreed upon confidentiality agreement. The City will contact United prior to releasing any information and give United the opportunity to review, respond, and/or object to the request. Once City receives notice of United's objection, City will not proceed until the outcome of court order is determined. This provision shall survive the termination of this Agreement.

Section 4.3 Access to Information. Other than as provided for in Section 4.4, if Customer needs access to United's Proprietary Business Information, United may allow Customer to use United's Proprietary Business Information, if it is legally permissible, the information relates to United's services under this Agreement, and Customer gives United reasonable advance notice and an explanation of the need for such information. Such use is subject to the terms of this Agreement and, if required by United, a mutually agreed upon confidentiality agreement.

If Customer is subject to a Freedom of Information Act (FOIA) or similar legal request for public records applicable to Customer and the request includes United's Proprietary Business Information, Customer will contact United prior to releasing any information and give United the opportunity to review, respond, and/or object to the FOIA request.

United will comply with the Colorado Open Records Act (CORA) to the extent such Act requires timely disclosure of public documents maintained by government contractors. If public records are required to be disclosed under CORA, the City will contact United prior to releasing any information and give United the opportunity to review, respond, and/or object to the CORA request, and it will be United's responsibility to seek a court order protecting such records, and to defend and indemnify the Customer from any claim or action related to the City's non-disclosure of such information. Once City receives notice of United's objection, City will not proceed until the outcome of court order is determined. United shall indemnify Customer for any fines Customer incurs as a result of United's objection.

United will provide information only while this Agreement is in effect and for a period of three (3) years after the Agreement terminates, unless Customer demonstrates that the information is required by law or for Plan administration purposes as required under ERISA.

United also will provide reasonable access to information to an entity providing Plan administrative services to Customer, such as a consultant or vendor, if Customer requests it. Before United provides Proprietary Business Information to that entity, the parties must sign a mutually agreed-upon confidentiality agreement, and the parties must agree as to what information is minimally necessary to accomplish the Plan administrative service.

Customer is responsible for entering into any and all legally required terms and/or agreements with consultant or vendor to ensure protection of the PHI, including but not limited to, a Business Associate Agreement, as defined under the Health Insurance Portability and Accountability Act and its implementing regulations, as amended from time to time.

Section 4.4 Medical Claims Audit. During the term of the Agreement, and at any time within six (6) months following its termination, a mutually agreeable entity may conduct an annual medical claims audit of United's performance under the Agreement once each calendar year. Prior to the commencement of this audit, United must receive a signed, mutually agreeable confidentiality agreement. As part of the annual medical claims audit, United will also support either a small targeted audit of appeals, member calls, or clinical transactions (not to exceed 25 transactions).

Customer must advise United in writing of its intent to audit. The place, time, type, duration, and frequency of all audits must be reasonable and agreed to by United. All audits will be limited to information relating to the calendar year in which the audit is conducted, and/or the immediately preceding calendar year.

With respect to United's claims processing services, the audit scope and methodology will be consistent with generally acceptable auditing standards, including a statistically valid random sample (not to exceed 400 claims transactions) as approved by United ("Scope"). United will not support any external audits a) where the audit firm is paid on a contingency basis, and b) that do not use a statistically valid random selection methodology (other than as provided for in this section); this includes electronic/data mining audits that are used for purposes of recovery discovery.

United will cooperate with Denver's Auditor should this contract be selected for a financial or performance audit as allowed by Denver's Charter and Revised Municipal Code.

Customer will pay any expenses that it incurs in connection with the audit. In addition, Customer will be charged a $350 per claim charge and a $1500 per day charge for any on-site audit visit that is not completed within five (5) business days or for sample sizes exceeding the Scope specified above. The additional fees cover the additional resources, facility fees, and other incremental costs associated with an audit that exceeds the Scope.

In addition to Customer's expenses, Customer will also pay any extraordinary expenses United incurs due to a Customer request related to the audit, such fees to be reviewed and approved by the Customer in advance. For any audit initiated after this Agreement is terminated, or for any audit in addition to those provided for in this Section (if approved by United), Customer $350 per claim charge and a $1500 per day charge .

Customer will provide United with a copy of any audit reports within thirty (30) days after Customer receives the audit report(s) from the auditor.

Section 4.5 Service Auditor Reports. United may make its Type II service auditor report ("Report") available to United's self-funded customers each year for Customer's review in connection with Plan administrative purposes only. The Report will be issued under the guidance of Statement on Standards for Attestation Engagements #16

(SSAE18). Should new guidelines covering service auditor reports be issued, United may make the equivalent of, or any successor to, the SSAE18 Type II Report available to United's self-funded customers. The Report is United's Proprietary Business Information and shall not be shared with any third parties without United's prior written approval, except that Customer can share the Report with: (i) Customer's independent public accounting firm; and/or (ii) Customer's consultants on the condition that such consultants are not in any way a competitor of United's and that Customer informs its consultants that the Report was not prepared for their use. To the extent that Customer does provide the Report to its independent public accounting firm or a consultant as permitted in this Section, Customer shall require that they retain the Report as confidential and that they not disclose such Report to any other persons or entities.

Section 4.6 PHI. The parties' obligations with respect to the use and disclosure of PHI are outlined in the Business Associate Addendum attached to this Agreement.

Section 5 – Taxes and Assessments

Section 5.1 Payment of Taxes and Expenses. In the event that any Taxes are assessed against United as a claim administrator in connection with United's services under this Agreement relating solely to: (1) the Plan; (2) Taxes relating to benefit payments under the Plan; or (3) United's fees or services under this Agreement (but not Taxes for any income, franchise or other tax based on United's income, capital or net worth), United has the authority and discretion to reasonably determine whether any such Tax should be paid or disputed. Subject to the Maximum Contract Amount and appropriation requirements in the Master Purchase Agreement, Customer will also reimburse United for a proportionate share of any cost or expense reasonably incurred by United in disputing such Tax, including costs and reasonable attorneys' fees and any interest, fines, or penalties relating to such Tax, unless caused by United's unreasonable delay or unreasonable determination to dispute such Tax.

If Customer notifies United that it does not wish United to represent Customer's interests in litigation challenging the tax, United shall not bill Customer for pro rata attorney's fees and costs from the time of notice forward, provided Customer has paid any tax and other amounts under this Section due and owing up to the point of receipt of notice by United from Customer. If Customer chooses to bring its own action against the jurisdiction assessing the tax, United shall provide reasonable cooperation and assistance.

Section 5.2 Tax Reporting. In the event that the reimbursement of any benefits to Participants in connection with this Agreement is subject to Plan or employer-based tax reporting requirements, Customer agrees to comply with these requirements.

Section 5.3 State and Federal Surcharges, Fees and Assessments. The Plan is responsible for state or Federal surcharges, assessments, or similar Taxes imposed by governmental entities or agencies on the Plan or United as identified in Section 5.1 above, including, but not limited to, those imposed pursuant to The Patient Protection and Affordable Care Act of 2010 ("PPACA"), as amended from time to time. This includes the funding, remittance, and determination of the amount due for PPACA required taxes and fees.

Section 6 – [Intentionally Left Blank]

Section 7 – Plan Benefits Litigation

Section 7.1 Litigation Against United. If a demand is asserted, or litigation or administrative proceedings are begun by a Participant or healthcare provider against United to recover Plan benefits related to its duties under this Agreement ("Plan Benefits Litigation"), United will select and retain defense counsel to represent its interest.

Section 7.2 Litigation Against Customer. If Plan Benefits Litigation is begun against Customer and/or the Plan, Customer will select and retain counsel to represent its interest.

Section 7.3 Litigation Against United and Customer. If Plan Benefits Litigation is begun against the Plan and United jointly, and provided no conflict of interest arises between the parties, the parties may agree to joint defense counsel. If the parties do not agree to joint defense counsel, then each party will select and retain separate defense counsel to represent their own interests.

Section 7.4 Litigation Fees and Costs. All reasonable legal fees and costs United incurs will be paid by Customer (except as provided in Section 6.2), subject to the Maximum Contract Amount and appropriation requirements in the Master Purchase Agreement, if United gives Customer reasonable advance notice of United's intent to charge Customer for such fees and costs, and United consults with Customer in a manner consistent with United's fiduciary obligations on United's litigation strategy.

In the event of litigation or legal action against the Plan, United will notify the City Attorney within a reasonable period of time and receive the City Attorney's consent to United's legal strategy and such consent shall not be unreasonably withheld.

Section 7.5 Litigation Cooperation. Both parties will cooperate fully with each other in the defense of Plan Benefits Litigation.

Section 7.6 Payment of Plan Benefits. In all events, Customer is responsible for the full amount of any Plan benefits paid as a result of Plan Benefits Litigation, subject to the Maximum Contract Amount and appropriation requirements in the Master Purchase Agreement.

Section 7.7 Survival. This provision shall survive the termination of this Agreement.

Section 8 – [Intentionally Blank]

Section 9 – Termination

Section 9.1 Services End. United's services under this Agreement stop on the date this Agreement terminates, regardless of the date that claims are incurred. However, United may agree to continue providing certain services beyond the termination date, as provided in Exhibit A – Statement of Work.

Section 9.2 Termination Events. This Self-Funded Benefits Plan Agreement will terminate under the following circumstances:

(1) The Plan terminates;

(2) Both parties agree in writing to terminate the Agreement;

(3) After the Initial Term, either party gives the other party at least sixty (60) days prior written notice; United gives Customer notice of termination because Customer did not pay the fees or other amounts Customer owed United when due under the terms of this Agreement;

(4) United gives Customer notice of termination if Customer fails to provide the required funds for payment of benefits under the terms of this Agreement;

Either party is in material breach of this Agreement, other than by non-payment or late payment of fees

(5) owed by Customer or the funding of Plan benefits, and does not correct the breach within thirty (30) days after being notified in writing by the other party;

(6) United may terminate this Agreement in the event of a filing by or against the Customer of a petition for relief under the Federal Bankruptcy Code;

(7) Any state or other jurisdiction prohibits a party from administering the Plan under the terms of this Agreement, or imposes a penalty on the Plan or United and such penalty is based on the administrative services specified in this Agreement. In this situation, the party may immediately discontinue the Agreement's application in such state or jurisdiction. Notice must be given to the other party when reasonably practical. The Agreement will continue to apply in all other states or jurisdictions; or

(8) As otherwise specified in this Agreement.

Section 10 – Miscellaneous

Section 10.1 Subcontractors. United can use its affiliates or subcontractors to perform United's services under this Agreement. United will be responsible for those services to the same extent that United would have been had it performed those services without the use of an affiliate or subcontractor.

Section 10.2 Assignment. Except as provided in this paragraph, neither party can assign this Agreement or any rights or obligations under this Agreement to anyone without the other party's written consent. That consent will not be unreasonably withheld. Nevertheless, United can assign this Agreement, including all of its rights and obligations to United's affiliates, to an entity controlling, controlled by, or under common control with United, or a purchaser of all or substantially all of United's assets, subject to notice to Customer of the assignment.

Section 10.3 Governing Law. This Agreement is governed by the laws of the State of Colorado. This provision shall survive the termination of this Agreement.

Section 10.4 [Left Blank].

Section 10.5 Amendment. Except as may otherwise be specified in this Agreement, the Agreement may be amended only by both parties agreeing to the amendment in writing, executed by a duly authorized person of each party.

Section 10.6 Waiver/Estoppel. Nothing in this Agreement is considered to be waived by any party, unless the party claiming the waiver receives the waiver in writing. No breach of the Agreement is considered to be waived unless the non-breaching party waives it in writing. A waiver of one provision does not constitute a waiver of any other. A failure of either party to enforce at any time any of the provisions of this Agreement, or to exercise any option which is provided in this Agreement, will in no way be construed to be a waiver of such provision of this Agreement.

Section 10.7 Notices. Any notices, demands, or other communications required under this Self-Funded Benefits Plan Agreement will be in writing and may be provided via electronic means or by United States Postal Service by certified or registered mail, return receipt requested, postage prepaid, or delivered by a service that provides written receipt of delivery.

Section 10.8 Compliance with Laws and Regulations. The parties agree to comply with all applicable federal, state and other laws and regulations with respect to this Agreement.

Section 10.9 No Third Party Beneficiaries. Nothing in this Agreement shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

Section 10.10 Severability. The invalidity or unenforceability of any provision of this Agreement will not affect the validity or enforceability of any other provision. However, it is intended that a court of competent jurisdiction construe any invalid or unenforceable provision of this Agreement by limiting or reducing it so as to be valid or enforceable to the extent compatible with applicable law.

Section 10.11 Order of Precedence. In the event of any conflicts between the language of this Agreement and its exhibits, the language of this Agreement controls unless such language has been severed because it was held to be invalid, illegal, or unenforceable.

EXHIBIT A – STATEMENT OF WORK

The following are the administrative services United has agreed to provide to Customer. Customer may request that United provide services in addition to those set forth in this Self-Funded Benefits Plan Agreement. If United agrees to provide them, those services will be governed by the terms of this Agreement and any amendments to this Agreement. Customer will pay an additional fee as clearly defined in an amendment and subject to appropriation as described in the Master Purchase Agreement between the parties, for these additional services. The Services described in this Exhibit A will be made available to Customer's eligible Participants consistent with the Summary Plan Description under which the Participant is covered.

Section A1 Network

Network Access, Management and Administration. United will provide access to Networks and Network Providers, as well as related administrative services including physician (and other health care professional) relations, clinical profiling, contracting and credentialing, and network analysis and system development. The make-up of the Network can change at any time. Notice will be given in advance or as soon as reasonably possible.

United generally does not employ Network Providers and they are not United's agents or partners, although certain Network Providers are affiliated with United. Otherwise, Network Providers participate in Networks only as independent contractors. Network Providers and the Participants are solely responsible for any health care services rendered to Participants. United is not responsible for the medical outcomes or the quality or competence of any provider or facility rendering services, including Network Pharmacies and services provided through United's affiliates' networks, or the payment for services rendered by the provider or facility.

Value Based Contracting Program. United's contracts with some Network Providers may include withholds, incentives, and/or additional payments that may be earned, conditioned on meeting standards relating to utilization, quality of care, efficiency measures, compliance with United's other policies or initiatives, or other clinical integration or practice transformation standards. Customer shall fund these payments earned the Network Providers as soon as United makes the determination the Network Provider is entitled to receive the payment under the Network Provider's contract, either upfront or after the standard has been met. For upfront funding, if United makes the determination that the Network Provider failed to meet a standard, United will return to Customer the applicable amount. United shall provide Customer reports describing the amount of payments made on behalf of Customer's Plan.

Only the initial claims based reimbursement to Network Providers will be subject to the Participant's copayment, coinsurance or deductible requirements. Customer will pay the Network Provider the full amount earned or attributable to its Participants, without a reduction for copayments or deductibles and agree that there will be no impact from these payments on the calculation of the Participant's satisfaction of their annual deductible amount.

Section A2 Recovery Services

Claim Recovery Services. United will provide recovery services for Overpayments and other Plan recovery opportunities as described herein. United will not be responsible for reimbursement of any unrecovered Overpayment nor attorneys' fees and costs related to litigation or arbitration associated with recoveries except to the extent an arbitrator, arbitration panel, or court of competent jurisdiction determines that the Overpayment was due to United's failure to meet the Standard of Care. Under no circumstances will United be responsible for reimbursement of unrecovered Overpayments resulting from a third party's fraud. If United does not pursue unrecovered Overpayments, then United will cooperate with Customer and timely provide Customer with information and documents sufficient for Customer to collect unrecovered Overpayments.

Overpayments. United utilizes generally-accepted auditing protocols to identify Overpayments. United will attempt to recover Overpayments by employing appropriate outreach to Participants and/or providers to request reimbursement.

Fraud, Waste, and Abuse Management. United will provide services related to detection, and recovery of wasteful, abusive, and/or fraudulent claims. United's Fraud, Waste, and Abuse Management processes will be based upon United's proprietary and confidential procedures, modes of analysis, and investigations. United will use these procedures and standards in delivering Fraud, Waste, and Abuse Management services to Customer and to United's other customers. Services include all work to identify recovery opportunities, research, data analysis, investigation, and initiation of all Recovery Processes set forth below. United does not guarantee or warranty any particular level of

prevention, detection, or recovery. United agrees to perform Fraud, Waste, and Abuse Management services pursuant to the industry standards for such services.

Credit Balance Recovery. United utilizes on-site resources to perform hospital and/or facility audits to review, validate, and recover credit balances (dollars) existing on patient accounts to identify any recoverable amounts.

Hospital Bill Audit. United utilizes on-site resources (registered/licensed nurses and/or certified coders) to perform in-depth reviews of hospital bills. Auditors will conduct line by line comparisons of itemized bills to the medical records to ensure billing accuracy and identify any recoverable amounts.

Injury Coverage Coordination (ICC). United will provide Customer with accident healthcare claim savings service on first party claims (such as workers compensation, automobile medical payments, or "No-fault" medical expense savings) through active coordination-of-benefits (COB). ICC works with the responsible property casualty insurance carrier, expediting claim payment by such insurance carrier and saving claim expense for Customer. During the term of this Agreement, Customer will not engage any entity except United to provide the services described herein without United's prior approval.

Subrogation. United will provide services to recover Plan benefits that were paid and are recoverable by the Plan because payment was or should have been made by a third party for the same medical expense (other than in connection with coordination of benefits, Medicare, or other Overpayments). This is referred to as "Third Party Liability Recovery" or "Subrogation". During the term of this Agreement, Customer will not engage any entity except United to provide the services described in this Section without United's prior approval.

Advanced Analytic Recovery Services. United will use large scale analytics, information, and analysis to identify post-adjudication claims for additional recovery opportunities.

Recovery Process – Non-Class Action Recoveries. Customer delegates to United the discretion and authority to develop and use standards and procedures for any recovery opportunity, including but not limited to, whether or not to seek recovery, what steps to take if United decides to seek recovery, whether to initiate litigation or arbitration, the scope of such litigation or arbitration, which legal theories to pursue in such litigation or arbitration, and all decisions relating to such litigation or arbitration, including but not limited to, whether to compromise or settle any litigation or arbitration, and the circumstances under which a claim may be compromised or settled for less than the full amount of the potential recovery. In all instances where United pursues recovery through litigation or arbitration, Customer, on behalf of itself and on behalf of its Plan(s), will be deemed to have granted United an assignment of all ownership, title and legal rights and interests in and to any and all claims that are the subject matter of the litigation or arbitration.

Customer acknowledges that use of United's standards and procedures may not result in full or partial recovery for any particular claim or for any particular Customer. United will not pursue any recovery if it is not permitted by any applicable law, or if recovery would be impractical, as determined in United's discretion. While United may initiate litigation or arbitration to facilitate a recovery, United has no obligation to do so. If United initiates litigation or arbitration, Customer will cooperate with United in the litigation or arbitration.

If this Agreement terminates, in whole or in part, United can continue recovery activities for any claims paid when the Agreement was in effect pursuant to the terms of this Section A2.

Recovery Process – Class Action Recoveries. Where a class action purports to affect Customer's (or the Plan(s) it sponsors or administers) right to and interest in any Overpayment, United has the right to determine whether to seek recovery of the Overpayment on the Customer's (or the Plan(s) it sponsors or administers) behalf through litigation, arbitration, or settlement. If United elects to seek recovery of such an Overpayment that is at issue in a class action, United will provide written notice to Customer of its intention. If Customer does not want United to seek recovery of the Overpayment, Customer shall notify United in writing within thirty (30) days of receiving notice from United. If Customer does not so notify United, Customer, on behalf of itself and on behalf of the Plan(s) it sponsors and administers, assigns to United all ownership, title and legal rights and interests in and to any and all Overpayments that are the subject matter of the class action. In such cases, Customer will cooperate with United in any resulting litigation or arbitration that United may file to pursue the Overpayments.

If Customer provides United with written notice that it does not want United to seek recovery of an Overpayment related to a class action (whether putative or certified) then, pursuant to its standard procedures, United will provide Customer with related Overpayment claims information, at Customer's request. Customer is then solely responsible for determining whether it (or the Plan(s) it sponsors or administers) will participate in the class action (whether putative or certified), participate in any class action settlement, pursue recovery of the relevant Overpayment outside

of the class action, or take any other action with respect to any cause of action the Customer (or the Plan(s) it sponsors or administers) might have.

Offsetting Process. In some instances, United may be able to obtain an Overpayment recovery by applying (or offsetting) the Overpayment against future payments to the provider made by United. In effectuating Overpayment recoveries through offset, United will follow its established Overpayment recovery rules which include, among other things, prioritizing Overpayment credits based on: (1) the age of the Overpayment for electronic payments and (2) the funding type and the age of the Overpayment for check payments. United may recover the Overpayment by offsetting, in whole or in part, against: (1) future benefits that are payable under the Plan in connection with services provided to any Participants; or (2) future benefits that are payable in connection with services provided to individuals covered under other self-insured or fully-insured plans for which United processes payments. In addition to permitting United to recover Overpayments on behalf of the Plan from benefits payable under other plans, United will enable other plans (including plans fully insured by United) to recover their Overpayments from benefits payable under the Plan. Customer understands and agrees that in doing so, the Plan is participating in a cooperative overpayment recovery effort with other plans for which United acts as the claims administrator. Reallocations pursuant to this process in no way impact the decision as to whether or not a benefit is payable under the Plan. In United's application of Overpayment recovery through offset, timing differences may arise in the processing of claims payments, disbursement of provider checks, and the recovery of Overpayments. As a result, the Plan may in some instances receive the benefit of an Overpayment recovery before United actually receives the funds from the provider. Conversely, United may receive the funds before the Plan receives the credit for the Overpayment. It is hereby understood that the Parties may retain any interest that accrues as a result of these timing differences. Details associated with Overpayment recoveries made on behalf of the Plan through offset will be identified in the monthly reconciliation report provided to the designated representative for the Customer's Plan. The monthly reconciliation report will contain information relating only to Customer's Plan and will not contain information relating to other plans for which United acts as the claims administrator.

Recovery Fees. Customer will be charged a fee for the services described in this Section A2. Those fees are set forth in Exhibit B – Fees, subject to appropriation as described in the Master Purchase Agreement between the parties.

Section A3 Providing Funds

Responsibility for Payment of Plan Benefits. The Plan is Self-Funded. Customer is solely responsible for providing funds for payment for all Plan benefits. United has no liability or responsibility to provide these funds. This is true even if United or its affiliates provide stop loss insurance to Customer.

Bank Account. United, on Customer's behalf, will open and maintain a Bank Account at a bank under United's sole control (the "Bank") for the benefit of the City and County of Denver to provide United the means to access City funds to make payment of Plan benefits, pre-authorized Plan expenses (such as state surcharges or assessments), or other Customer financial obligations as directed by the Customer. The Bank Account will be a part of the network of accounts that have been established at the Bank for United's self-funded customers. The appropriated funds in the Bank Account are Customer's and are held for the benefit of the Customer and any remaining balance will be returned to the City in the event of termination of this Agreement and completion of the run-out services, and such funds will not be comingled with any other funds or accounts.

Balance In Account. Customer will make an agreed initial deposit in the Bank Account and will maintain a minimum balance in the Bank Account in an amount agreed by the parties. The Parties will establish this amount based on expected Plan payment obligations, with appropriate adjustments for anticipated non-daily activity (e.g., prescription drug benefits and fee payments) as determined by United and pre-authorized by Customer. United will notify Customer if and when the required minimum balance or the amount changes.

The required minimum balance is based on Customer's financial condition as reasonably assessed by United. In the event United determines, based on reasonable information and belief, that Customer's financial condition has deteriorated, or Customer continues to fail to comply with the material financial obligations specified in this Agreement, United may revise the required balance effective five (5) days from the date of notice to Customer.

Issuing and Providing Funds for Checks and Non-Draft Payments. Checks and/or non-draft payments will be written on and/or issued from one or more common accounts that are a part of the network of accounts maintained at the Bank for United's self-funded customers. When the checks for Plan benefits are presented to the Bank, the Bank

will notify United and United will direct the Bank to either reject the checks or to withdraw funds from the Bank Account to fund the checks that are cashed.

Transfers of Funds. Funds will also be withdrawn from the Bank Account when a transfer of funds has been made electronically. United will direct the Bank to withdraw funds from the Bank Account to fund the non-draft payments or expenses as they are issued.

Calls for Funds. The withdrawals from the Bank Account are paid for by the balance Customer maintains in the Bank Account. This balance will be drawn down each banking day to satisfy the previous day's liability.

Every 5 business day(s), United will notify Customer of the funding amounts that are due. Upon notice to Customer of the amount due, Customer will fund the designated amount(s) within one business day via Automated Clearing House (ACH) transfer to the designated Bank Account for payment of Plan benefits.

The number of days between transfers and the method of transfer will be agreed upon by the Parties. The Parties will increase the frequency of such fund transfers as necessary to timely, properly and fully fund the Bank Account.

Underfunding. If Customer does not provide the amounts sufficient to maintain the required minimum balance in the Bank Account, or to cover Bank Account withdrawals: (1) Customer must immediately correct the deficiency and provide prompt notice to United. (2) If United learns of the funding deficiency, United will notify Customer within one business day so Customer can correct the deficiency. (3) United may stop issuing checks and non-draft payments and suspend any of its other services under this Agreement for the period of time Customer does not provide the required funding. (4) If Customer does not correct the funding deficiency within three banking days of United's notice to Customer, United may terminate this Agreement as otherwise set forth in this Agreement, such termination to be effective the first day such funding deficiency began. The interest rate United charges its self-funded customers is not to exceed the prime rate within the Agreement Period, plus 4%, and in all events any interest changes shall be in accordance with the City's prompt payment ordinance D.R.M.C. § 20-107, et seq.

Stop Payments on Outstanding Checks. At Customer's expense, United may place stop payments on checks if United determines that Customer has insufficient funds in its own designated funding bank account to honor such checks. United will send a search letter to the payee on all checks that have not been cashed within six (6) months. United will automatically stop payment on all checks that have not been cashed within twelve (12) months and provide Customer with reports Customer needs for the purposes of performing escheat. Customer is solely responsible for determining to file and/or filing unclaimed property once notified, or for making unclaimed payee payments directly.

Funding After Termination. When this Agreement terminates, the funding method will remain in place to fund all outstanding checks and Customer's other funding obligations, including credit refunds due to the Customer, for the length of the run-out period. Following the run-out period, to ensure a minimally sufficient balance is maintained to cover Customer's funding obligations, the required minimum balance may be adjusted through mutual agreement of the parties. United will stop payment on all checks that remain uncashed at the end of this period and Customer will request in writing to close the Bank Account and recover any funds remaining in it. United will provide bank statements and Bank Account reconciliation reports, including reports Customer needs for the purposes of performing escheat.

Section A4 Medical Benefit Drug Rebate Payments

Allocation and Payment of Medical Benefit Drug Rebates. From time to time, United or a subcontractor may negotiate with drug manufacturers regarding the payment of Medical Benefit Drug Rebates on applicable prescription drug products dispensed to Participants under the Plan's medical benefit. Customer will receive 80% of the Medical Benefit Drug Rebates United receives. United will retain the balance of such Medical Benefit Drug Rebates as part of United's compensation. When United negotiates directly with drug manufacturers for the payment of Medical Benefit Drug Rebates to United, United will pay Customer the agreed upon Medical Benefit Drug Rebates within thirty (30 calendar days of United's receipt of such Medical Benefit Drug Rebates from the drug manufacturer. If United is not able to make payment to Customer within thirty (30) calendar days, United will pay interest on such Medical Benefit Drug Rebates from the date of receipt until United makes payment to Customer, less approximately thirty (30) days for processing. United will retain interest earned during this processing timeframe. Interest will be paid at the one month London Interbank Offered Rate (LIBOR) in effect on the first business day of each applicable month.

Customer will only receive Customer's Medical Benefit Drug Rebates to the extent that Medical Benefit Drug Rebates are actually received by United. Thus, for example, if a government action or a major change in pharmaceutical

industry practices prevents United from receiving Medical Benefit Drug Rebates, the amount Customer receives may be reduced or eliminated.

Customer agrees that during the term of this Agreement, neither Customer nor the Plan will negotiate or arrange or contract in any way for Medical Benefit Drug Rebates on or the purchase of prescription drug products from any manufacturer under the Plan's medical benefit. If Customer or the Plan does, United may, without limiting United's right to other remedies, immediately terminate Customer's and Plan's entitlement to Medical Benefit Drug Rebates (including forfeiture of any Medical Benefit Drug Rebates earned but not paid). In addition, Customer agrees to reasonably cooperate with United in order to obtain Medical Benefit Drug Rebates. Nothing herein shall prevent or penalize Customer from negotiating during the term of this Agreement, a Self-Funded Benefits Plan Agreement and corresponding drug rebate program with the intention of hiring a vendor to replace United.

Subcontractor Compensation. If a subcontractor is involved in negotiating with drug manufacturers regarding the payment of Medical Benefit Drug Rebates, it may retain a portion of the gross amounts received from drug manufacturers in connection with such products. United will provide information on the amount, if any, retained by the subcontractor as compensation for its services, in advance of Customer's execution of this Agreement. In addition, United will provide Customer with thirty (30) days advance notice of any material increase in or method for subcontractor compensation. If at any time Customer does not find the subcontractor compensation acceptable, the Parties will work to resolve the issue by agreement, otherwise Customer may terminate the Medical Benefit Drug Rebates services after thirty (30) days advance written notice to United.

Section A5 Claims Determinations and Appeals

Claim Procedures. Customer appoints United a named fiduciary under the Plan with respect to (i) performing initial benefit determinations and payment, and (ii) performing the fair and impartial review of first level internal appeals and (iii) performing the fair and impartial review of second level internal appeals. As such, Customer delegates to United the discretionary authority to (i) construe and interpret the terms of the Plan, (ii) to determine the validity of charges submitted to United under the Plan, and (iii) make final, binding determinations concerning the availability of Plan benefits under the Plan's internal appeal process, all in compliance with applicable law and regulation. If United denies a Plan benefit claim, in whole or in part, United will notify the claimant of the adverse benefit determination and the claimant shall have the appeal rights set forth in the Summary Plan Description, and/or those which are required under applicable law. If after the exhaustion of the two levels of internal appeal, United determines that the Plan benefit is still not payable, United will notify the claimant that the adverse benefit determination has been upheld. This determination will be final and binding on the claimant, and all other interested parties, except as otherwise provided under the external review program described in this Section A5.

Appeals of Urgent Care Claims. Notwithstanding the foregoing, with respect to Urgent Care Claims, United will conduct one review of a denied Urgent Care Claim and issue a final determination as soon as possible, in accordance with applicable law.

External Review Program. United will notify claimants of the option to request an external review of adverse benefit determinations following the required internal appeal process. United will, in accordance with applicable law: (i) provide claimant with the necessary procedures to obtain the review (ii) coordinate submission of the claimant's case to an independent review organization, and (iii) direct the independent review organization to notify the claimant of the final external review decision. A fee will apply beyond the maximum number of free reviews, as listed in Exhibit B - Fees.

Catastrophic Events. During such time as a government agency declares a state of emergency or otherwise invokes emergency procedures with respect to Participants who may be affected by severe weather or other catastrophic events (a "Catastrophic Event Timeframe"), Customer directs United to implement certain changes in its claim procedures for affected Participants, including, for example: (a) exemption from the application of prior authorization requirements and/or penalties; (b) waiver of out-of-network restrictions (e.g., out-of-network providers paid at the Network Provider level) , (c) extension of time frames for timely claims filing and/or appeals, (d) early replacement of lost or damaged durable medical equipment, and (e) other protocols reasonably required to provide Participants with access to health plan and pharmacy benefits as applicable. Such protocols are applicable to Participants whose place of residency falls within impacted areas of the Catastrophic Event, and for dates of service that fall within the Catastrophic Event Timeframe.

Section A6 Systems Access

Access. United grants Customer the nonexclusive, nontransferable right to access and use the functionalities contained within the Systems, under the terms specified in this Agreement. Customer agrees that all rights, title, and interest in the Systems and all rights in patents, copyrights, trademarks, and trade secrets encompassed in the Systems will remain United's. To obtain access to the Systems, Customer will obtain, and be responsible for maintaining, at no expense to United, the hardware, software, and Internet browser requirements United provides to Customer, including any amendments thereto. Customer will be responsible for obtaining an Internet Service Provider or other access to the Internet. Customer will not (i) access Systems or use, copy, reproduce, modify, or excerpt any Systems documentation provided by United in order to access or utilize Systems, for purposes other than as expressly permitted under this Agreement or (ii) share, transfer or lease Customer's right to access and use Systems, to any other person or entity which is not a party to this Agreement. Customer may designate any third party, with prior approval from United, to access Systems on Customer's behalf, provided the third party agrees to these terms and conditions of Systems access and Customer assumes joint responsibility for such access.

Security Procedures. Customer will use commercially reasonable physical and software-based measures to protect the passwords and user IDs provided by United for access to and use of any web site provided in connection with the services. Customer shall use commercially reasonable anti-virus software, intrusion detection and prevention system, secure file transfer and connectivity protocols to protect any email and confidential communications provided to United, and maintain appropriate logs and monitoring of system activity, Customer shall notify United within a reasonable timeframe of any (a) unauthorized access or damage, including damage caused by computer viruses resulting from direct access connection, and (b) misuse and/or unauthorized disclosure of passwords and user IDs provided by United which impact the System.

Termination. United reserves the right to terminate Customer's System access (i) on the date Customer fails to accept the hardware, software and browser requirements provided by United, including any amendments thereto or (ii) immediately on the date United reasonably determines that Customer has (i) breached, or allowed a breach of, any applicable provision of this Section or (ii) materially breached or allowed a material breach of, any other applicable provision of this Agreement. Customer's System Access will also terminate upon termination of this Agreement, provided however that if run-out is provided in accordance with Exhibit A - Services, Customer may continue to access applicable functionalities within the Systems during the run-out period. Upon any of the termination events described in this Agreement, Customer agrees to cease all use of Systems, and United will deactivate Customer's identification numbers, passwords, and access to the System.

Section A7 Pharmacy Benefit Services

Definitions Specific to Pharmacy Benefit Services:

Average Wholesale Price (AWP): The average wholesale price, as reflected on the Medi-Span Prescription Pricing Guide (with supplements) ("Medi-Span"), of a Prescription Drug based on the eleven (11) digit NDC of the Drug on the date dispensed. United will rely on Medi-Span as updated by United no less frequently than every seven days to determine AWP for purposes of establishing the pricing provided to Customer under this agreement. United will not establish AWP, and United will have no liability to Customer arising from use of Medi-Span.

Brand Drug: A single-source or multi-source prescription drug product which is manufactured and marketed under a trademark or name by a specific drug manufacturer and that the Medi-Span Prescription Pricing Guide (with supplements) or other available data resources that identify as a Brand product.

Dispensing Fee: The contracted rate of compensation paid to a Network Pharmacy for the processing and filling of a prescription claim.

Prescription Drug List (PDL): The list of Prescription Drugs covered by the applicable Plan as developed by United and approved and adopted by Customer for use with the Plan. The PDL will be made available to physicians, pharmacies and other healthcare providers or entities to guide the prescribing, dispensing, sale and coverage of prescription services.

Generic Drug: A prescription drug product that is chemically equivalent to a Brand drug and that Medi-Span Prescription Pricing Guide (with supplements) or other available data resource that identify as a Generic product.

MAC: The maximum allowable cost of a Prescription Drug as specified on a list established by United. United may have multiple MAC lists, each of which is subject to United's periodic review and modification.

Mail Order Pharmacy: A facility that is duly licensed to operate as a pharmacy at its location and to dispense Prescription Drugs via postal or commercial courier delivery to individuals, including Participants. Mail Order Pharmacy includes pharmacies that are affiliates of United.

Network Pharmacy: A retail pharmacy, Mail Order Pharmacy, Specialty Pharmacy or other facility that is duly licensed to operate as a pharmacy at its location and to dispense Prescription Drugs to Participants and has entered into a Network Pharmacy agreement. An affiliate of United, in its capacity as a Mail Order Pharmacy or Specialty Pharmacy is a Network Pharmacy of the Customer.

Prescription Drug: A medication or product, including a Brand Drug or Generic Drug, that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Rebate: Any discount, rebate administration fees, price concession or other direct or indirect remuneration United receives from a drug manufacturer under a rebate agreement that is contingent upon and related directly to Participant use of a prescription drug under the Plan's pharmacy benefit or the medical benefit during the Term. Rebate does not include any discount, price concession or other direct or indirect remuneration United receives from a drug manufacturer for direct purchase of a prescription drug.

Single-Source Generic: A Generic Drug that has only one generic manufacturer.

Specialty Drugs: Prescription Drugs available at United's Specialty Pharmacy, including: (a) biotechnology drugs; (b) orphan drugs used to treat rare diseases; (c) typically high-cost drugs; (d) drugs administered by oral or injectable routes, including infusions in any outpatient setting; (e) drugs requiring on-going frequent patient management or monitoring; and (f) drugs that require specialized coordination, handling and distribution services for appropriate medication administration

Specialty Pharmacy: A facility that is duly licensed to operate as a pharmacy to dispense Specialty Drugs. Specialty Pharmacy includes pharmacies that are affiliates of United.

Pharmacy Network. United or its affiliate will provide the Pharmacy Benefit Services described in this Section. United will make Network Pharmacies available to Customer Participants, through United's affiliate. United will determine which pharmacies are Network Pharmacies. Network Pharmacies can change at any time. United will make a reasonable effort to provide Customer with advance notice if any material changes occur to the network. Upon request, United will provide Customer information on the reimbursement rate to United's affiliated Network Pharmacies.

Mail Order Pharmacy Services. United will provide, through its affiliate, mail order pharmacy services for Customer's Participants. Customer's pricing terms for mail order pharmacy services are based on the actual package dispensed and at least a 46 day supply. Prescriptions filled through the mail order pharmacy that are less than a 46 day supply will be processed at retail pricing and will be counted with retail utilization.

Prescription Drug List (PDL). Customer has adopted one or more of United's PDLs for use with Customer's benefit plans. Customer agrees not to copy, distribute, sell, or otherwise provide the PDL to another party without United's prior written approval, except to Participants as described below. On termination of this Agreement or if Customer terminates the Pharmacy Benefit Services portion of this Agreement, Customer will stop all use of the PDL.

While Customer is the ultimate decision-maker on selecting the design of Customer's PDL(s), Customer has requested that United supply and assist Customer with, certain PDL development and management functions including but not limited to drug tiering decisions. United's intent is to provide Customer with the same PDL and management strategies that United develops and employs in the management of United's fully insured business.

United makes the final classification of an FDA-approved prescription drug product to a certain tier of the PDL by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the prescription drug product, as well as whether supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the prescription drug product's acquisition cost including, but not limited to, available Rebates, and assessments on the cost effectiveness of the prescription drug product.

United may periodically change the placement of a prescription drug product among the tiers and/or recommend specific prescription drug product exclusions from coverage. These changes generally will occur three times per year, but no more than six times per calendar year. These changes may occur without prior notice to Customer however United will provide notice to Customer of material changes to the PDL, United's drug tier classification procedures, coverage exclusions, and clinical programs. If Customer chooses not to implement a particular coverage exclusion or clinical program change, Customer needs to inform United in writing sixty (60) days prior to the effective date of the exclusion or change. Current drug placement and related information may be obtained from the website, or by calling customer service.

Claims Processing. United will process the claims received from a Network Pharmacy in accordance with the Summary Plan Description, as well as the pricing and other terms of the Network Pharmacy's participation agreement. On mail order, specialty and retail pharmacy services, United will retain the difference between what United reimburses the Network Pharmacy and Customer payment for a prescription drug product or service.

United maintains systems for processing pharmacy claims and may receive access fees as compensation for services United provides to Network Pharmacies.

Pharmacy Audits. During the term of the Agreement, and at any time within six (6) months following its termination, a mutually agreeable entity ("Auditor") may conduct an annual pharmacy claims audit of United's performance under the Agreement once each calendar year. Prior to the commencement of this audit, United must receive a signed, a mutually agreeable confidentiality agreement.

Customer must advise United in writing of its intent to audit. The place, time, type, duration, and frequency of all audits must be reasonable and agreed to by United. No audits may be initiated or conducted during the months of December and January due to the demands of annual renewals and the implementation period. All audits will be limited to information relating to the calendar year in which the audit is conducted, and/or the immediately preceding calendar year. The audit scope and methodology will be consistent with generally acceptable auditing standards, including a statistically valid random sample as approved by United. United will not support any external audits a) where the audit firm is paid on a contingency basis, or b) that do not use a statistically valid random selection methodology; this includes electronic/data mining audits that are used for purposes of recovery discovery.

Customer will pay any expenses that it or its Auditor incurs in connection with the audit. In addition to Customer's expenses and any applicable fees, Customer will also pay any extraordinary expenses United incurs due to a customer request related to the audit, such fees to be reviewed and approved by the Customer in advance. For any audit initiated after this Agreement is terminated or for any audit in addition to those provided for in this Section (if approved by United), Customer will pay all expenses incurred by United.

United will provide Auditor with access to prescription claims data, subject to the provisions of the confidentiality agreement. Additional documentation (e.g. policies and procedures) requested during the course of an audit, other than that needed to determine the accuracy of pharmacy claims payments, may be provided at United's reasonable discretion. After reviewing the claims for the audit period, Auditor may provide a sample size of claims, not to exceed 300 prescription claims per audit, for United to perform additional research.

A final audit report shall be provided by Customer or Auditor in writing to United forty-five (45) days after the end of the audit. Such final audit report will contain a representative sample of prescription claims or the entire suspected error population, as well as the dollar amount associated with any suspected errors. If the entire suspected error population is provided, then United will review a statistically valid sample of the prescription claims and provide Customer or Auditor with its response within forty-five (45) days of United's receipt of the final audit report. Customer or its Auditor shall have thirty (30) calendar days to reply to United's response. If Customer or its Auditor fail to provide either the initial final audit report or fail to reply to United's audit response within the timeframes provided, then the audit will be considered closed. Any payment made, whether by United or Customer, based upon audit findings will be made within thirty (30) days following Customer and United agreeing to the audit results and payment of any amounts due as reflected in an executed audit settlement agreement.

Without limiting the foregoing, with respect to audits regarding the payment of Rebates by pharmaceutical manufacturers, the audit must be conducted solely by a "big four" public accounting firm (currently defined as Deloitte, Ernst & Young, KPMG and PricewaterhousecCoopers) that maintains a separate and stand-alone audit department and is not providing support in conjunction with any litigation pending against United or United's affiliates. However, the parties may agree in writing to use another mutually agreeable firm meeting such

requirements. Rebate audits are to be conducted separate from claims audits, must be conducted on site at United, and are limited to five (5) Rebate agreements.

Section A8 Pharmacy Benefit Rebates

Allocation and Payment of Rebates. United will negotiate with drug manufacturers for the payment of Rebates to United. United will retain 100% of the Rebates paid to United and any related interest. The amount of Rebates retained depends on many factors, including whether Customer has an incentive benefit design, arrangements with drug manufacturers, the volume of prescription drug claims and the structure of the PDL.

In the event a government action or a major change in pharmaceutical industry practices eliminates or materially reduces manufacturer Rebate programs, Customer's payment amount may be reduced or eliminated. In such event, United shall promptly notify Customer and revise or eliminate such payment effective with the date of the reduction or elimination in Rebate payments. In addition, reduction or elimination of Rebates in this event shall constitute a change in the Agreement as described in the Fees Section such that United has the right to increase the fees for the Pharmacy Benefits Management services. Termination of pharmacy benefit services shall constitute a change in the Agreement as described in the Fees Section such that United has the right to increase Customer fees under this Agreement.

Payments to Pharmacies. In connection with prescription drug claims, there may be a timing difference between when United withdraw funds from Customer claims account and when United issues payments to pharmacies and other payees. United may retain interest earned on these amounts during this time. Interest is expected to be paid at overnight deposit rates by United's banking institution.

Customer Compliance. Customer agrees that during the term of this Agreement, neither Customer nor the Plan will negotiate or arrange or contract in any way for Rebates on or the purchase of prescription drug products from any manufacturer with respect to the pharmacy benefits, unless Customer is doing so as part of a conversion to a new service provider who is to replace United as the result of a competitive bid. If Customer or the Plan does, in violation of this provision, United may, without limiting United's right to other remedies, immediately terminate Customer and Plan's entitlement to Rebates (including forfeiture of any Rebates earned but not paid) and/or terminate the pharmacy benefit services. Termination of pharmacy benefit services shall constitute a change in the Agreement as described in the Fees Section such that United has the right to increase the fees for medical management services under this Agreement. In addition, Customer agrees to reasonably cooperate with United in order to obtain Rebates. Customer will encourage Customer Participants to use a Network Pharmacy. Customer will also encourage Customer Participants to electronically access the PDL on United's website, and encourage Participants to share the PDL with their physicians or refer their physicians to the PDL on United's website.

Coordination of Pharmacy Benefits with Medicare Part D. If elected by Customer, Customer delegates the discretion and authority to United to develop and use policies and procedures to coordinate claims for retiree pharmacy benefits claims with Customer Part D prescription drug plan in accordance with Customer Plan design and applicable law.

Section A9 Health Savings Account (HSA)

Health Savings Account (HSA). United will provide Customer with an HSA in accordance with Exhibit A - Statement of Work. Customer acknowledges that HSAs are subject to contribution limits and other requirements imposed by the IRC and associated guidance issued by the IRS/Treasury Department. Customer acknowledges and agrees that United shall have no obligation to ensure compliance with any requirements or limitations pertaining to HSAs, their establishment and/or use. To the extent that Customer has established contribution amounts and other HSA program requirements applicable to Customer Enrolling Employees, Customer will advise United of such requirements. United will not verify that distributions from Customer's Enrolling Employees' HSAs are for qualified medical expenses.

Schedule of Services

A. Account Management Services

Service	Comments
Implementation and maintenance of account.	
Enrollment meetings and support for locations that meet United's criteria.	Minimum six weeks notice of meeting.
Standard initial enrollment kit.	
Bulk mailing of initial enrollment kits to Customer based on United's criteria.	
Ongoing account management including: • Designated account resources. • Ongoing management and review of benefits and data.	
Standard accounting structure based on United's criteria: • Suffixes to accommodate separate claims reporting for different benefit plans. • Claim accounts to accommodate separate claims data for different locations and groups.	
Maintenance of benefit plans.	
Electronic Bill Presentment and Payment (EBPP), which provides capabilities to: • View invoices online. • Sort and search enrollee information. • Download billing information. • Remit payment online.	
Online administration services accessed through United's Employer eServices Web site including online eligibility maintenance and claim status inquiry.	Customer reporting is included to the extent indicated in Section D. eServices Customer Reporting Services.
Summary Plan Description (SPD) Assistance. United will prepare a customized draft of an SPD, either for each plan or multiple plans, as mutually agreed upon with one additional draft, in response to Customer's comments, and a final draft SPD. "Plan", for purposes of this paragraph, means each individual plan design administered by United. The SPD will be in English.	If the SPD is not finalized sufficiently in advance of the Effective Date of United's services, United will either (i) utilize the summary of Plan benefits and exclusions that United has created based on its understanding of Customer's Plan design and which Customer has reviewed and approved or (ii) create, at United's discretion, an operational SPD which will be based upon the summary of Plan benefits that Customer has reviewed and approved. United will administer claims and otherwise provide its services in accordance with this summary of Plan benefits and exclusions or operational SPD, as the case may be, and it will govern and remain in full force and effect until a final SPD is provided to United. Printing of SPDs is available at an additional cost.
Summary of Benefits and Coverage: • Electronic version in United's standard format. • For medical Plans administered by United. • Initial request and up to 1 amendment per year.	

B. Eligibility Management Services

Service	Comments
Standard ID Card production and issuance.	United has assumed the addition of Customer's logo in an acceptable format to the ID card and in compliance with Denver's Brand Guidelines.
Alternative member ID numbers generated by United (not based on SSN).	
Electronic Eligibility Processing	
Electronic Enrollment processing: • Each submission to be a single consolidated file. Separate eligibility submissions for COBRA. • Initial load of primary physician data (when applicable) to be supplied electronically.	

Service	Comments
Submission format: • UnitedHealth Group® Standard 3005 Format; HIPAA 834 Compliant Format; or HR-XML format. • Single data source required. **Submission frequency:** • Changes file daily in combination with a full population file on a monthly schedule. **Or** • Changes file weekly or bi-weekly in combination with a full population file on a monthly or quarterly schedule. **Or** • Full file weekly or bi-weekly**.** **Transmission method:** • FTP with United's approved encryption or direct connect.	

C. UNDERWRITING AND FINANCIAL SERVICES

Service	Comments
Overall program accounting (year-end reconciliation).	
Claim projections.	
Annual Projection of cost impact for benefit design changes.	
Annual Projection of conventional premium equivalent rates.	
Annual Reserve estimates.	
Annual government filings of 1099 reports to the IRS regarding payments made to physicians and other health care professionals.	
Provide required data, which is in the solely in the control of United, necessary to enable Customer to file Form 5500, and any other required tax reporting documents.	

D. ESERVICES® CUSTOMER REPORTING SERVICES

Service	Comments
An online customer reporting system including up to five customer IDs.	
Reporting Access Levels: • Standard – Basic report package of "subscription" financial and utilization information produced on a pre-scheduled basis. •	
Non-standard or ad hoc reports	Fees are determined on a report-specific basis
United reserves the right, from time to time, to change the content, format and/or type of its reports.	

E. CLAIMS ADMINISTRATION SERVICES

Service	Comments
Claims for Plan benefits must be submitted in a form that is satisfactory to United in order for it to determine whether a benefit is payable under the Plan's provisions. Customer delegates to United the discretion and authority to use United's claim procedures and standards for Plan benefit claim determination.	
Implementation of Customer's benefit plans.	
Claim history load from one prior carrier using United's standard process.	
Standard claims processing including: • Re-pricing and payment of claims. • Auto and manual adjudication using proprietary software. • Claim edit/review and cost containment program • Pending and subsequent claim review.	
Standard claim forms (when applicable).	

Service	Comments
Medical claim review of specific health care claims to promote coding accuracy, benefit interpretation, and apply reimbursement policy.	
Standard coordination of benefits for all claims with automated investigation once every 12 months.	
Production and distribution of monthly Health Statements.	
Processing of run-out claims (meaning claims incurred prior to the termination date) for six (6) months following termination.	If the Agreement terminates because Customer fails to pay United fees due, fails to provide the funding for the payment of benefits, or United terminates for any other material breach, run-out will not apply. Run-out fees shall apply to partial terminations. The fee for six (6) months run-out claims processing is equal to the last two months' Standard Medical Service Fees in effect at the time of termination, and no other monthly run-out claims processing service fee will be charged concurrently during the runout period. If Customer terminates this Agreement at the end of the Initial Term, a matured Standard Medical Service Fee will be used as the basis for the run-out fee. United will bill Customer for the full amount of run-out fee that Customer owes, generally one month prior to the Agreement's termination date. The full payment of run-out fees is due and payable before run-out claims processing will begin. United will only process run-out claims if Customer is current with all fee obligations at time of termination. **Suspension of Run-out Processing** If Customer does not pay the run-out fees it owes United when due as set forth above, United will notify Customer. If Customer does not make the required payment within five (5) business days of United's notice to Customer, United may stop issuing checks and non-draft payments and suspend its run-out claims processing under this Agreement, such suspension to apply to all claims regardless of dates of service and shall remain in effect until such date when Customer makes the required payment. **Termination of Run-out Processing** Run-out claims processing will terminate: (1) the date United gives Customer notice of termination because Customer did not pay the run-out fees Customer owed United when due as set forth above, or (2) if Customer fails to provide the required funds for payment of benefits under the terms of this Agreement. Such termination shall apply to all claims regardless of dates of service.
Subrogation Services.	
Fraud and Abuse Management Recovery Program.	
Hospital Bill Audit Program.	
Credit Balance Recovery Program.	
Advanced Analytics and Recovery Services	United or its affiliate will use a combination of large scale analytics, information and analysis to identify post-adjudication claims for additional overpayment opportunities.

F. MEMBER SERVICES

Service	Comments
Toll-free access to a customer care unit using a dedicated number	
Employee access to a member website enabling Participants to: • Check claim status. • Check eligibility information. • Search for providers and online health information.	

G. MEDICARE SERVICES

Service	Comments
Medicare crossover	
Medicare Part D Subsidiary Services. If elected by Customer, provide to Customer or Customer's designee, or, at Customer's request directly to CMS, information Customer has determined is necessary for Customer to comply with the requirements of the RDS program consisting of our standard reporting, in a format compliant with all applicable CMS submission procedures and deadlines.	If elected by Customer, Customer will provide United with any information that United reasonable requires in order to prepare these reports, including but not limited to Plan Variation/Reporting Code used to isolate members for whom Customer is pursuing the Retiree Drug Subsidy and/or the members' social security numbers of Health Information Codes. Customer hereby represents that Customer has entered into a disclosure agreement with the Plan to allow the release of required information to CMS. Customer has informed United and United acknowledges that information provided in connection with the services under this Agreement is used for purposes of obtaining Federal funds.
Medicare Secondary Payer Reporting. United shall provide to applicable parties the applicable reports in a time and manner as required according to the Medicare Secondary Payer Mandatory Reporting Provisions (the Reporting Requirements) in Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007. United shall not be responsible for any noncompliance penalties in connection with the Reporting Requirements that are related to the Customer's failure to provide the required data.	Customer agrees to provide to United in a timely manner and in an agreed upon format any and all data that United requires to comply with the Reporting Requirements.

H. NETWORK SERVICES

Service	Comments
Network access, management and administrative activities	Standard on all network plans.
UnitedHealth Premium[SM] Designation Program	Available in designated markets.
Reasonable and customary charge guidelines for out of network surgical, medical, lab and x-ray claims.	
Maximum Non-Network Reimbursement Program (MNRP) for non-emergency non-network claims.	
Shared Savings Program Standard Application of the Shared Savings Program provides additional savings on select 1) non-Network facility and 2) physician claims that are not eligible for standard network discounts. Program provides access to discounted charges made available to United from health care providers who contract or will negotiate with, a third party to provide such discounted charges.	The services under this program provide access to provider discounts only and do not include credentialing of providers or other Network services. United is not responsible for the medical outcomes or the quality or competence of any provider or facility rendering services under the Shared Savings Program. United can terminate the Shared Savings Program at any time for any reason. Notice of termination will be provided as soon as reasonably possible.

I. CARE MANAGEMENT SOLUTIONS SERVICES

Service	Comments
Personal Health Support **Health advocates and concierge services,** includes the following: • Central in-take point for all clinical and lifestyle Participant calls. • Access to registered nurses for symptom triage and support with decisions about health care and treatment options as applicable to the Customer's elected products. • Health education and resource navigation. • Low to moderate health risk management. • Premium provider / facility locating and appointment scheduling. **Personal nurses,** provide targeted support. **Specialty nurses**, provide clinical management for complex conditions. **Personal Health Support Website** **Consumer activation and outreach campaigns**, United may create consumer marketing campaigns to promote clinical, lifestyle management and advocacy services to the Customer's Participants. **Reporting**, outlining program activity and impact. Additional services include the following: **Disease Management** • Asthma • Chronic Obstructive Pulmonary Disease (COPD) • Coronary Artery Disease (CAD) • Diabetes • Congestive Heart Failure (HF) **Complex Medical Conditions:** • Cancer Resource Services • Congenital Heart Disease Resource Services • Kidney Resource Services • Orthopedic Health Support **Transplant Resource Services:** • Transplant Network via Centers of Excellence (COE) • Transplant Access Program (TAP) Network • Extra-Contractual Services - contracting on a case-by case basis for transplant care outside of the COE or TAP Networks for a standard negotiating fee. **Women's Health:** • Maternity Program • Parent Steps Infertility Discount Program **Health Content:** Providing members with access to online services which may include but are not limited health and wellness content, health assessments, health coaching, personal health records and/or automated messaging, available through myuhc.com and other online resources. **Physical Health Solutions** • Chiropractic Network • PT/OT/ST Network • Chiropractic Clinical Support Program (CCSP) • Clinical Support Program - PT/OT Complementary Alternative Medicine (CAM) Network Management **Advocacy** • EAP • Decision Support	
Medical policy functions, as guided by a medical director.	Standard on all managed plans.

Service	Comments
Alternate Care Proposals (ACP) which provide appropriate and cost effective health care services and supplies alternatives that would otherwise not be covered by the Plan.	Customer consents to United's use and administration of the ACP program and delegate to United the discretion and authority to develop and revise ACPs.
Activation programs to engage Participants including, monthly health statements member call services, and access to member portal with consumer messaging	
Predictive modeling, using data from a proprietary system, to identify individuals at risk and offer proactive programs to improve their health status.	Additional charges apply for integrating an outside vendor's pharmacy data. As of the effective date pharmacy services are being provided by United.

J. UNITED BEHAVIORAL HEALTH — MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

Service	Comments
Behavioral Health Solutions • Network access, development and maintenance • Ongoing case management. • Outpatient care management. • Inpatient care management. • Interventions for Inpatient and Outpatient outliers. • Claims processing, adjudication and member services. • Account management and standard reporting • Interface Integration with employee assistance program (EAP) vendors • Applied Behavioral Analysis (ABA) for Autism if Customer chooses to cover ABA as a Plan benefit, including ABA clinical management • Participant referrals to licensed care manager from disease management and case management programs.	

K. MANAGED PHARMACY SERVICES

Service	Comments
Integrated Pharmacy Services and General Support. United to provide administrative, management, consultative and general support as it relates to prescription drug benefit plan services, mail order pharmacy services and specialty pharmacy services to support the Plan	
• **Account management** and support staff • **Benefits administration** and support • **Claims Processing** • **Clinical programs** such as standard notification, quantity level limits, and quantity per duration. • **Credentialing of Contracted Pharmacies** • **Customer Care Center Services -** Toll-free access to customer care voice response unit (for location of network pharmacies), and a pharmacist • **Eligibility management** • **Mail Order Pharmacy Services** • **Medication Adherence Savings** • **PDL Management** • **Pharmacy Network Management** • **Pharmacy Benefit Rebate Administration** • **Prior Authorization Services** • **Quality Assurance Program** • **Reporting** (available through eServices) • **Specialty Pharmacy Services Step Therapy** • **Targeted Disease Intervention Program** • **Utilization Management Program -** Development and Support • **Additional programs such as** dispense as written (DAW) interventions, retail flags and edits, maximum	

Service	Comments
allowable cost pricing (retail), and generic and mail order programs • Upon termination of the Agreement, United will provide transition files (open refill, prior authorization, non-financial claims history) to a successor pharmacy benefits manager	

L. HEALTH SAVINGS ACCOUNT (HSA) SERVICES

Service	Comments
Standard HSA services. United's affiliate will be Customer's preferred HSA custodian for eligible employees' HSAs. United will provide the following services in relation to those HSA custodial services: • Pre-enrollment brochures – one per employee. • Human Resources Communication Toolkit. • Provide access to bank account information through a member website for account holders enrolled in health plans administered by United.	

EXHIBIT B – FEES

This exhibit lists the fees Customer must pay United for its services during the term of the Agreement. These fees apply for the period from January 1, 2020 through December 31, 2022. Customer acknowledges that the amounts paid for administrative services are reasonable. If expressly authorized by Customer pursuant to this Agreement or by subsequent authorization, certain fees will be paid through a withdrawal from the Bank Account.

Standard Medical Service Fees

The Standard Medical Service Fees described below, excluding optional and non-standard fees, are adjusted as set forth in the applicable performance standard(s).

The Standard Medical Fees listed below are based upon an estimated minimum of 3,965 enrolled Employees.

The Standard Medical Service Fees are the sum of the following:

- $36.05 per Employee per month covered under the Choice Plus HSA and Doctor's Plan Choice portion(s) of the Plan.
- **Average Contract Size:** 2.11

Pharmacy AWP Contract Rate

Customer's contract rate for prescription drugs is as provided in Exhibit C. United uses Medi-Span's national drug data file as the source for average wholesale price (AWP) information. United reserves the right to revise the pricing and adopt a new source or benchmark if there are material industry changes in pricing methodologies.

Other Fees

In total, Other Fees defined in this section are subject to the Maximum Contract Amounts recited in the Master Purchase Agreement between the parties.

Service Description	Fee
Fraud and Abuse Management	Fee equal to thirty-two and five-tenths percent (32.5%) of the gross recovery amount
Hospital Audit Program Services	Fee equal to thirty-one percent (31%) of the gross recovery amount
Credit Balance Recovery Services	Fee equal to ten percent (10%) of the gross recovery amount.
Standardized Summary of Benefits and Coverage (SBC) as established under The Patient Protection and Affordable Care Act of 2010	United will provide, at no additional charge, standard format, electronic copies of the SBC documents (twice per year) for medical benefit plans administered by United. Customer logos can be included on the SBC at no additional charge. Additional fees will apply for other services. United will not create SBCs for medical plans it does not administer.
Injury Coverage Continuation (ICC) Services	Fees are assessed based on the estimated claim savings and fee equal to one-third (33.33%) of the calculated savings amount.
Third Party Liability Recovery (Subrogation) Services	Fee equal to thirty-three and one-third percent (33.3%) of the gross recovery amount
Shared Savings Program	Customer will pay a fee equal to thirty-five percent (35%) of the Savings Obtained as a result of the Shared Savings Program. The savings used to calculate the fee per individual claim for Shared Savings will not exceed $50,000. Accordingly, the fee per individual claim will not exceed thirty-five percent (35%) of $50,000.

	The Shared Savings Program fees will not exceed $12.00 per Employee per month for savings achieved on services through the year, to be reconciled annually. Savings Obtained means the amount that would have been payable to a health care provider, including amounts payable by both the Participant and the Plan, if no discount were available, minus the amount that is payable to the health care provider, again, including amounts payable by both the Participant and the Plan, after the discount is taken.
External Reviews	For each subsequent external review beyond 5 total reviews per year, a fee of $500 will apply per review.

Wellness Allowance

United will provide a wellness allowance so Customer may enhance Customer medical benefits during the term of the Agreement. The wellness allowance may be used at Customer's discretion as Customer utilizes wellness programming and services from United. If Customer terminates the Agreement prior to December 31, 2022, Customer will pay United a prorated portion of this credit.

$300,000 Wellness annual allowance (not subject to roll-over)

EXHIBIT C – PERFORMANCE STANDARDS FOR HEALTH BENEFITS

The Standard Medical Service Fees (excluding Optional and Non-Standard Fees and that portion of the Standard Medical Service Fees attributable to Commission Funds, if applicable, as described in Exhibit B - Fees), (hereinafter referred to as "Fees in this Exhibit") payable by Customer under this Self-Funded Benefits Plan Agreement ("Agreement") will be adjusted through a credit to its fees in accordance with the performance guarantees set forth below unless otherwise defined in the guarantee. Unless otherwise specified, these guarantees apply to medical benefits and are effective for the period January 1, 2020 through December 31, 2022 ("Guarantee Period"), and for every calendar year through December 31, 2022 thereafter that the Self-Funded Insurance Plan Agreement until this Exhibit is replaced by United. With respect to the aspects of United's performance addressed in this exhibit, these fee adjustments are Customer's exclusive financial remedies under this Exhibit C.

These guarantees will become effective upon the later of (1) the effective date of the Guarantee Period; or (2) the date this Agreement is signed by both parties. In the event these guarantees become effective later than the effective date of the Guarantee Period: (1) quarterly guarantees will become effective beginning with the next calendar quarter following signature of this Agreement by both parties and (2) annual guarantees will become effective commencing with the Term of the Agreement during which this Agreement is signed by both parties.

United shall not be required to meet any of the guarantees provided for in this Agreement or amendments thereto to the extent its failure is due to Customer's actions or inactions or if United fails to meet these standards due to fire, embargo, strike, war, accident, act of God, acts of terrorism or United's required compliance with any law, regulation, or governmental agency mandate or anything beyond United's reasonable control.

Prior to the end of the Guarantee Period, and on the condition that this Agreement remains in force, United may specify to Customer in writing new performance guarantees for the subsequent Guarantee Period. If United specifies new performance guarantees, United will also provide Customer with a new Exhibit that will replace this Exhibit for that subsequent Guarantee Period.

Claim is defined as an initial and complete written request for payment of a Plan benefit made by an enrollee, physician, or other healthcare provider on an accepted format. Unless stated otherwise, the claims are limited to medical claims processed through the UNET claims systems. Claims processed and products administered through any other system, including claims for other products such as vision, dental, flexible spending accounts, health reimbursement accounts, health savings accounts, or pharmacy coverage, are not included in the calculation of the performance measurements. Also, services provided under capitated arrangements are not processed as a typical claim; therefore capitated payments are not included in the performance measurements.

Implementation -- Applies to First Year Only January 1, 2020 through December 31, 2020			
A formal implementation plan, which defines key tasks, dependencies and completion dates will be developed and agreed to by both parties. The lack of a mutually agreeable formal implementation plan will nullify these implementation guarantees in total. Failure on the customer's part to complete, by the agreed upon dates, the key dependent tasks associated with the implementation guarantees outlined below will also nullify that guarantee.			
Initial ID Card Issuance			
Definition	ID cards will be postmarked within the parameters set forth after the final eligibility data has been system loaded, passed a quality assurance check, passed a system load test and has been released to the ID card production area.		
Measurement	Percentage of cards issued		99%
	Issuance time frame, business days or less	business days	10
Criteria	Calculated on a pro-rated basis, based on the actual number of late cards as a percent of the total number of cards. ID card turnaround time guarantees are based on United's performance during the implementation process.		
Level	Customer specific		
Period	Initial implementation timeframe		
Payment Period	Annually		

Fees at Risk	Total Dollars Payable for this metric		$15,500
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		N/A
Gradients	Not applicable		
Claim Ready Date			
Definition	Ready to pay electronic claims by the later of the effective date or within the designated number of days following the completion of key implementation tasks: (i) Account structure and benefit plan details are defined and written approval has been provided by the customer; (ii) final eligibility has been received and successfully tested by United; and (iii) if so negotiated, deductibles and lifetime maximums from the previous carrier received in a mutually agreed upon format, accurate, and loaded electronically.		
Measurement	Electronic claim ready by effective date or the later of business days or less	business days	18
Criteria	If any additional changes are received or requested after written approval is received, 10 additional business days will be required for changes affecting up to ten benefit plans (sets); 20 additional days will be required for changes affecting ten or more benefit plans (sets).		
Level	Customer specific		
Period	Initial implementation timeframe		
Payment Period	Annually		
Fees at Risk	Total Dollars Payable for this metric		$15,500
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		N/A
Gradients	Not applicable		
Eligibility Loading			
Definition	Initial implementation electronic eligibility files will be loaded within the timeframe set forth following receipt of clean eligibility file.		
Measurement	Files loaded, in business days or less	business days	3
Criteria	Clean eligibility file once approved by Customer and/or its designee and United, which must be: a) error free; b) formatted per United's standards; and c) received by 12:00 p.m., EST on the scheduled date, or the guarantee period starts the following business day.		
Level	Customer specific		
Period	Initial implementation timeframe		
Payment Period	Annually		
Fees at Risk	Total Dollars Payable for this metric		$15,500
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		N/A
Gradients	Not applicable		
Claim Operations January 1, 2020 through December 31, 2022			
Time to Process in 10 Days			
Definition	The percentage of all claims United receives will be processed within the designated number of business days of receipt.		
Measurement	Percentage of claims processed		94%
	Time to process, in business days or less after receipt of claim	business days	10
Criteria	Standard claim operations reports		
Level	Site Level		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars Payable for this metric		$15,500
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	11 business days 12 business days 13 business days 14 business days 15 business days or more		

Dollar Accuracy (DAR)			
Definition	Dollar accuracy rate of not less than the designated percent in any quarter.		
Measurement	Percentage of claims dollars processed accurately		99%
Criteria	Statistically significant random sample of claims processed is reviewed to determine the percentage of claim dollars processed correctly out of the total claim dollars paid.		
Level	Office Level		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars Payable for this metric		$15,500
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	98.99% - 98.50% 98.49% - 98.00% 97.99% - 97.50% 97.49% - 97.00 Below 97.00%		
Procedural Accuracy			
Definition	Procedural accuracy rate of not less than the designated percent.		
Measurement	Percentage of claims processed without procedural (i.e. non-financial) errors		97%
Criteria	Statistically significant random sample of claims processed is reviewed to determine the percentage of claim dollars processed without procedural (i.e. non-financial) errors.		
Level	Office Level		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars Payable for this metric		$15,500
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	96.99% - 96.50% 96.49% - 96.00% 95.99% - 95.50% 95.49% - 95.00% Below 95.00%		
Member Phone Service			
Phone service guarantees and standards apply to Participant calls made to the customer care center that primarily services Customer's Participants. If Customer elects a specialized phone service model the results may be blended with more than one call center and/or level. They do not include calls made to care management personnel and/or calls to the senior center for Medicare Participants, nor do they include calls for services/products other than medical, such as mental health/substance abuse, pharmacy (except when United is Customer's pharmacy benefit services administrator), dental, vision, Health Savings Account, etc.			
Average Speed to Answer			
Definition	Calls will sequence through United's phone system and be answered by customer service within the parameters set forth.		
Measurement	Percentage of calls answered		100%
	Time answered in seconds, on average	seconds	30
Criteria	Standard tracking reports produced by the phone system for all calls		
Level	Team that services Customer's account		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars Payable for this metric		$15,500
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	32 seconds or less 34 seconds or less 36 seconds or less 38 seconds or less Greater than 38 seconds		

Abandonment Rate			
Definition	The average call abandonment rate will be no greater than the percentage set forth		
Measurement	Percentage of total incoming calls to customer service abandoned, on average		2%
Criteria	Standard tracking reports produced by the phone system for all calls		
Level	Team that services Customer's account		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars Payable for this metric		$15,500
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	2.01% - 2.50% 2.51% - 3.00% 3.01% - 3.50% 3.51% - 4.00% Greater than 4.00%		
Call Quality Score			
Definition	Maintain a call quality score of not less than the percent set forth		
Measurement	Call quality score to meet or exceed		93%
Criteria	Random sampling of calls are each assigned a customer service quality score, using United's standard internal call quality assurance program.		
Level	Office that services Customer's account		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars Payable for this metric		$15,500
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	92.99% - 91.00% 90.99% - 89.00% 88.99% - 87.00% 86.99% - 85.00% Below 85.00%		
Satisfaction			
Employee (Member) Satisfaction			
Definition	The overall satisfaction will be determined by the question that reads “Overall, how satisfied are you with the way we administers your medical health insurance plan?”		
Measurement	Percentage of respondents, on average, indicating a grade of satisfied or higher		80%
Criteria	Operations standard survey, conducted over the course of the year; may be customer specific for an additional charge.		
Level	Office that services Customer's account		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars Payable for this metric		$7,550
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		N/A
Gradients	Not applicable		
Customer Satisfaction			
Definition	The overall satisfaction will be determined by the question that reads “How satisfied are you overall with UnitedHealthcare?”		
Measurement	Minimum score on a 10 point scale	score	5
Criteria	Standard Customer Scorecard Survey		
Level	Customer specific		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars Payable for this metric		$7,550
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		N/A
Gradients	Not applicable		

Pharmacy Financials January 1, 2020 through December 31, 2022				
Definition	Contracted pharmacy rates that will be delivered to You.			
Measurement and Criteria		**01/01/2020**	**01/01/2021**	**01/01/2022**
	Component Discount Guarantee - Broad Network			
	Retail Brand, Average Wholesale Price (AWP) less	18.1%	18.3%	18.5%
	Retail Generic, AWP less	82.5%	83.0%	83.2%
	Mail Order Brand, AWP less	24.5%	24.6%	24.7%
	Mail Order Generic, AWP less	86.0%	86.0%	86.0%
	The Guaranteed Discount amount will be determined by multiplying the AWP by the guaranteed discount off AWP by each component.			
	Dispensing Fees - Broad Network			
	Retail Brand	$0.70	$0.69	$0.67
	Retail Generic	$0.70	$0.69	$0.67
	Dispensing fee totals are calculated by multiplying the actual scripts for each type by the contracted rate for that script type.			
	Fixed Rebate Guarantee (Advantage PDL)			
	Basis, per script	Brand	Brand	Brand
	Retail - 30 and 90 Day	$117.15	$120.77	$131.45
	Mail Order	$339.62	$346.85	$366.18
	Specialty	$1,434.88	$1,468.61	$1,627.35
Level	Customer Specific			
Period	Annually			
Payment Amount -- Discounts	The amount the actual discounts are less than the guaranteed discount amount for each individual component.			
Payment Amount -- Dispensing Fees	The amount the combined actual dispensing fee exceeds the combined contracted dispensing fee.			
Payment Amount -- Rebates	The amount the combined actual Rebate amount is less than the combined guaranteed Rebate amount.			
Conditions	**Discount & Dispense Fee Specific Conditions** • Discounts are based on actual Network Pharmacy brand and generic usage of retail and mail order drugs. The guaranteed discount amount will be determined by multiplying the AWP by the contracted discount rate off AWP by component. • Does not apply to items covered under the Plan for which no AWP measure exists. • Discounts calculated based on AWP less the ingredient cost; discount percentages are the discounts divided by the AWP. Discounts for retail and mail order generic prescriptions represent the average AWP based on savings off Maximum Allowable Cost (MAC) pricing for MAC generics and percentage discount savings off AWP for non-MAC generics. All other discounts represent the percentage discount savings off of AWP. • The arrangement excludes compound drugs, retail out of network claims, mail order drugs (for dispensing fee arrangement) and non-drug items. • The Arrangement excludes usual & customary claims, vaccines, long term care facility claims, veterans' affairs facility claims, over-the-counter claims. • When a drug is identified as a brand name drug, it will be considered a brand name drug for the calculation of discount guarantees. When a drug is identified as a generic drug, it will be considered a generic drug for the calculation of discount guarantees.			

-	• Specialty drugs dispensed outside United's specialty Pharmacy Network are included in the retail guarantees. Specialty drugs dispensed through United's specialty Pharmacy Network are excluded from the Retail and Mail guarantees.
-	• Drugs in the following Specialty therapeutic categories are included in the retail guarantees: HIV.
	Rebate Specific Conditions
	• Assumes implementation of United's Advantage PDL as applicable to the Choice Plus HSA and the Essential PDL as applicable to Doctor's Plan Choice.
	United reserves the right to modify or eliminate this arrangement as follows based upon changes in Rebates:
	• if changes made to United's PDL, for the purpose of achieving a lower net drug cost for Customer and United's other ASO customers, result in significant reductions to the Rebate level
	• if the percentage of enrolled pharmacy members with coverage access to authorized brand alternatives exceeds 50%
	• in the event that there are material deviations to the anticipated timing of drugs that will come off patent and no longer generate Rebates
	• if there is a change impacting the availability or amount of Rebates offered by drug manufacturer(s), including changes related to the elimination or material modification of a drug manufacturer(s) historic models or practices related to the provision of Rebates
-	• United will pay Fixed Rebates consistent with the Agreement. To the extent Rebates paid to United exceed the Fixed Rebate amount, We will retain the excess, including any Rebates United may earn on prescription drug products in any tiers not included in this arrangement and any related interest.
-	• Rebate Administrative Fee: United maintains systems and processes necessary for managing and administering Rebate programs. As consideration for these efforts, pharmaceutical manufacturers pay United administrative fees in addition to Rebates. Rebate Administration fees are included in the guaranteed rebate arrangement.
-	• If Customer terminates pharmacy benefit services with United prior to 12/31/2022, United will retain any and all pending or future Rebates payable under the Agreement as of the effective date of the termination of pharmacy benefit services.
-	• Drugs in the following Specialty therapeutic categories are included in the retail per-Brand guarantees: HIV.
-	• Over-the-counter and repackaged drugs, vaccines and devices are excluded from the script counts.
	General Conditions
	• Guarantee terms are subject to change based on an evaluation of customer specific utilization data
	• On mail order drugs and retail pharmacy drugs and services including dispensing fees, United will retain the difference between what United reimburses the Network Pharmacy and Customer's payment for a prescription drug product or service.
	• A minimum of 3,562 Employees and 7,522 Participants enrolled in the pharmacy plan is required.
	• The lessor of three logic (non-ZBL) will apply to Participant payments. Participants pay the lessor of the discounted price, the usual and customary charge or the cost share amount.
	• 100% Participant Paid Claims (Zero Balance Claims) will be included in discount guarantees, with discounts calculated based on the ingredient cost before the subtraction of member paid amount
	• All pricing guarantees require the selection of United as the exclusive mail provider.
	• Point of Sale Discount Administration Applies
	• United reserves the right to revise or revoke this arrangement if: a) changes in federal, state or other applicable law or regulation require modifications; b) there are material changes to the AWP as published by the pricing agency that establishes the AWP as used in these arrangements; c) Customer makes benefit changes that impact the arrangements; d) there is a material industry change in pricing methodologies resulting in a new source or benchmark; e) it is not accepted within ninety (90) days of the issuance of our initial quote; f) if Customer does not adopt M = MSMS mail program; g) Customer utilizes a vendor, that facilitates steering members to different drugs or pharmacies to the extent these services impact the financial guarantees under this Agreement.
TRRX (09/2019)	Following the initial eighteen month (18) months of the Agreement (but not before), Sponsor or its designee may provide PBM a written firm proposal for pharmacy benefit management services offered by a pharmacy benefit management service provider to Sponsor which takes into account, the aggregate plan design, clinical and trend programs, pharmacy network, specialty pharmacy and mail pharmacy utilization,

	demographics and other relevant factors for comparable companies ("Sponsor Current Market Price"). PHM shall have a reasonable opportunity to evaluate the Sponsor's Current Market Price. If the Sponsor or its designee conclude that the Sponsor's Current Market Price would yield an annual five percent (5%) or more savings of the Net Plan Costs (with Net Plan Costs defined as the sum of the cost of Covered Drugs, dispensing fees, and claims administrative fees, less Rebates received by Sponsor) under the Agreement, and PBM is unable or unwilling to offer new terms and conditions that would result in savings offered by competing offer, as determined by the Sponsor or its designee, then Sponsor may terminate the Agreement upon ninety (90) days' prior written notice to PBM.

Specialty Pharmacy **January 1, 2020 through December 31, 2022**	
Specialty Pharmacy Discount Guarantee	
Definition	Specialty drug discount level based on actual specialty drug utilization of the drugs listed below for the specialty drugs dispensed through United's specialty Pharmacy Network.
Measurement	A composite of 17.0% for drugs dispensed through United's specialty Pharmacy Network. This guarantee is effective 01/01/2020 through 12/31/2022. See chart below for a list of Specialty Drugs. Specialty drugs not included on the list below and dispensed through United's specialty Pharmacy Network will be guaranteed at a discount of 9.5%.
Criteria	Actual utilization, using Average Wholesale Price (AWP) in dollars, using our data, of listed specialty drugs through Our specialty Pharmacy Network will be multiplied against the discount target of 17.0% to determine the overall discount target dollars. The overall discount target dollars may be adjusted based on utilization of unlisted drugs to which the separate 9.5% discount applies. This total will be compared to actual discounts achieved for these drugs during the Guarantee Period.
Level	Customer Specific
Period	Annual
Payment Period	Annual
Payment Amount	The amount the combined actual specialty drug discounts are less than the 17.0% composite discount drug target.
Conditions	• Discounts calculated based on the AWP less the ingredient cost; discount percentages are the discounts divided by the AWP. Discounts for retail generic prescriptions represent the average savings off AWP based on Maximum Allowable Cost (MAC) pricing for MAC generics and percentage discount savings off AWP for non-MAC generics. All other discounts represent the percentage discount savings off of AWP. • Specialty drugs dispensed outside United's specialty Pharmacy Network, drugs for which no AWP measure exists and non-drug items are excluded. • Specialty drugs typically covered under the medical benefit (administered / handled by a provider, administered in a physician's office, ambulatory or home infusion) are excluded. • United reserves the right to revise or revoke this guarantee if: a) changes in federal, state or other applicable law or regulation require modifications; b) there are material changes to the AWP as published by the pricing agency that establishes the AWP as used in this guarantee; c) Customer makes benefit changes that impact the guarantee; d) there is a material industry change in pricing methodologies resulting in a new source or benchmark; e) if actual specialty utilization is not substantially similar to that in the experience period data on which our quote is based. • On specialty drugs, United will retain the difference between what United reimburses the Network Pharmacy and Customer's payment for a prescription drug product or service.

Specialty Drug Category	Drug Name	Included In/Excluded From Guarantee	Specialty Drug Category	Drug Name	Included In/Excluded From Guarantee
ANEMIA	ARANESP	Included	HIV	SYMTUZA	Excluded
ANEMIA	EPOGEN	Included	HIV	TENOFOVIR	Excluded
ANEMIA	PROCRIT	Included	HIV	TIVICAY	Excluded
ANEMIA	RETACRIT	Included	HIV	TRIUMEQ	Excluded
ANTICONVULSANT	EPIDIOLEX	Included	HIV	TRIZIVIR	Excluded
ANTIHYPERLIPIDEMIC	JUXTAPID	Included	HIV	TRUVADA	Excluded
ANTI-INFECTIVE	ARIKAYCE	Included	HIV	TYBOST	Excluded
ANTI-INFECTIVE	DARAPRIM	Included	HIV	VIDEX	Excluded
CARDIOVASCULAR	NORTHERA	Included	HIV	VIDEX EC	Excluded
CNS AGENTS	AUSTEDO	Included	HIV	VIRACEPT	Excluded
CNS AGENTS	FIRDAPSE	Included	HIV	VIRAMUNE	Excluded
CNS AGENTS	HETLIOZ	Included	HIV	VIRAMUNE XR	Excluded
CNS AGENTS	INGREZZA	Included	HIV	VIREAD	Excluded
CNS AGENTS	RILUTEK	Included	HIV	ZERIT	Excluded
CNS AGENTS	RILUZOLE	Included	HIV	ZIAGEN	Excluded
CNS AGENTS	SABRIL	Included	HIV	ZIDOVUDINE	Excluded
CNS AGENTS	TETRABENAZINE	Included	IMMUNE MODULATOR	ACTIMMUNE	Excluded
CNS AGENTS	TIGLUTIK	Included	IMMUNE MODULATOR	ARCALYST	Included
CNS AGENTS	VIGABATRIN	Included	INFERTILITY	BRAVELLE	Included
CNS AGENTS	VIGADRONE	Included	INFERTILITY	CETROTIDE	Included
CNS AGENTS	XENAZINE	Included	INFERTILITY	CHORIONIC GONADOTROPIN	Included
CNS AGENTS	XYREM	Included	INFERTILITY	FOLLISTIM AQ	Included
CYSTIC FIBROSIS	BETHKIS	Included	INFERTILITY	GANIRELIX ACETATE	Included
CYSTIC FIBROSIS	CAYSTON	Included	INFERTILITY	GONAL-F	Included
CYSTIC FIBROSIS	KALYDECO	Included	INFERTILITY	GONAL-F RFF	Included
CYSTIC FIBROSIS	KITABIS PAK	Included	INFERTILITY	MENOPUR	Included
CYSTIC FIBROSIS	ORKAMBI	Included	INFERTILITY	NOVAREL	Included
CYSTIC FIBROSIS	PULMOZYME	Included	INFERTILITY	OVIDREL	Included
CYSTIC FIBROSIS	SYMDEKO	Included	INFERTILITY	PREGNYL	Included
CYSTIC FIBROSIS	TOBI	Included	INFLAMMATORY CONDITIONS	ACTEMRA	Included

CYSTIC FIBROSIS	TOBI PODHALER	Included	INFLAMMATORY CONDITIONS	CIMZIA	Included
CYSTIC FIBROSIS	TOBRAMYCIN	Included	INFLAMMATORY CONDITIONS	COSENTYX	Included
ENDOCRINE	BUPHENYL	Included	INFLAMMATORY CONDITIONS	DUPIXENT	Included
ENDOCRINE	CARBAGLU	Included	INFLAMMATORY CONDITIONS	EMFLAZA	Included
ENDOCRINE	CHENODAL	Included	INFLAMMATORY CONDITIONS	ENBREL	Included
ENDOCRINE	CUPRIMINE	Included	INFLAMMATORY CONDITIONS	HUMIRA	Included
ENDOCRINE	CYSTADANE	Included	INFLAMMATORY CONDITIONS	ILUMYA	Included
ENDOCRINE	CYSTARAN	Included	INFLAMMATORY CONDITIONS	KEVZARA	Included
ENDOCRINE	DEPEN TITRATABS	Included	INFLAMMATORY CONDITIONS	KINERET	Included
ENDOCRINE	EGRIFTA	Included	INFLAMMATORY CONDITIONS	OLUMIANT	Included
ENDOCRINE	FIRMAGON	Included	INFLAMMATORY CONDITIONS	ORENCIA	Included
ENDOCRINE	GATTEX	Included	INFLAMMATORY CONDITIONS	OTEZLA	Included
ENDOCRINE	H.P. ACTHAR	Included	INFLAMMATORY CONDITIONS	RIDAURA	Included
ENDOCRINE	JYNARQUE	Included	INFLAMMATORY CONDITIONS	SILIQ	Included
ENDOCRINE	KEVEYIS	Included	INFLAMMATORY CONDITIONS	SIMPONI	Included
ENDOCRINE	KORLYM	Included	INFLAMMATORY CONDITIONS	STELARA	Included
ENDOCRINE	KUVAN	Included	INFLAMMATORY CONDITIONS	TALTZ	Included
ENDOCRINE	MYALEPT	Included	INFLAMMATORY CONDITIONS	TREMFYA	Included
ENDOCRINE	NATPARA	Included	INFLAMMATORY CONDITIONS	XELJANZ	Included
ENDOCRINE	NITYR	Included	INFLAMMATORY CONDITIONS	XELJANZ XR	Included
ENDOCRINE	OCTREOTIDE ACETATE	Included	IRON OVERLOAD	EXJADE	Included
ENDOCRINE	PROCYSBI	Included	IRON OVERLOAD	FERRIPROX	Included
ENDOCRINE	RAVICTI	Included	IRON OVERLOAD	JADENU	Included
ENDOCRINE	SAMSCA	Included	LIVER DISEASE	OCALIVA	Included
ENDOCRINE	SANDOSTATIN	Included	MONOCLONAL ANTIBODY MISCELLANEOUS	BENLYSTA	Included
ENDOCRINE	SIGNIFOR	Included	MULTIPLE SCLEROSIS	AMPYRA	Included

ENDOCRINE	SODIUM PHENYLBUTYRATE	Included	MULTIPLE SCLEROSIS	AUBAGIO	Included
ENDOCRINE	SOMATULINE DEPOT	Included	MULTIPLE SCLEROSIS	AVONEX	Included
ENDOCRINE	SOMAVERT	Included	MULTIPLE SCLEROSIS	BETASERON	Included
ENDOCRINE	SYPRINE	Included	MULTIPLE SCLEROSIS	COPAXONE	Included
ENDOCRINE	THIOLA	Included	MULTIPLE SCLEROSIS	DALFAMPRIDIN	Included
ENDOCRINE	TRIENTINE	Included	MULTIPLE SCLEROSIS	EXTAVIA	Included
ENDOCRINE	XERMELO	Included	MULTIPLE SCLEROSIS	GILENYA	Included
ENDOCRINE	XURIDEN	Included	MULTIPLE SCLEROSIS	GLATIRAMER	Included
ENZYME DEFICIENCY	CHOLBAM	Included	MULTIPLE SCLEROSIS	GLATOPA	Included
ENZYME DEFICIENCY	CYSTAGON	Included	MULTIPLE SCLEROSIS	PLEGRIDY	Included
ENZYME DEFICIENCY	GALAFOLD	Included	MULTIPLE SCLEROSIS	REBIF	Included
ENZYME DEFICIENCY	MIGLUSTAT	Included	MULTIPLE SCLEROSIS	REBIF REBIDOSE	Included
ENZYME DEFICIENCY	ORFADIN	Included	MULTIPLE SCLEROSIS	TECFIDERA	Included
ENZYME DEFICIENCY	PALYNZIQ	Included	MULTIPLE SCLEROSIS	ZINBRYTA	Included
ENZYME DEFICIENCY	STRENSIQ	Included	NEUTROPENIA	FULPHILA	Included
ENZYME DEFICIENCY	SUCRAID	Included	NEUTROPENIA	GRANIX	Included
ENZYME DEFICIENCY	TEGSEDI	Included	NEUTROPENIA	LEUKINE	Included
ENZYME DEFICIENCY	ZAVESCA	Included	NEUTROPENIA	NEULASTA	Included
GAUCHERS DISEASE	CERDELGA	Included	NEUTROPENIA	NEUPOGEN	Included
GROWTH HORMONE DEFICIENCY	GENOTROPIN	Included	NEUTROPENIA	NIVESTYM	Included
GROWTH HORMONE DEFICIENCY	HUMATROPE	Included	NEUTROPENIA	UDENYCA	Included
GROWTH HORMONE DEFICIENCY	INCRELEX	Included	NEUTROPENIA	ZARXIO	Included
GROWTH HORMONE DEFICIENCY	NORDITROPIN	Included	ONCOLOGY - INJECTABLE	ELIGARD	Included
GROWTH HORMONE DEFICIENCY	NUTROPIN AQ	Included	ONCOLOGY - INJECTABLE	INTRON A	Included

GROWTH HORMONE DEFICIENCY	OMNITROPE	Included	ONCOLOGY - INJECTABLE	LEUPROLIDE	Included
GROWTH HORMONE DEFICIENCY	SAIZEN	Included	ONCOLOGY - INJECTABLE	SYLATRON	Included
GROWTH HORMONE DEFICIENCY	SEROSTIM	Included	ONCOLOGY - INJECTABLE	SYNRIBO	Included
GROWTH HORMONE DEFICIENCY	ZOMACTON	Included	ONCOLOGY - ORAL	ABIRATERONE	Included
GROWTH HORMONE DEFICIENCY	ZORBTIVE	Included	ONCOLOGY - ORAL	AFINITOR	Included
HEMATOLOGIC	BERINERT	Included	ONCOLOGY - ORAL	AFINITOR DISPERZ	Included
HEMATOLOGIC	CABLIVI	Included	ONCOLOGY - ORAL	ALECENSA	Included
HEMATOLOGIC	CINRYZE	Included	ONCOLOGY - ORAL	ALKERAN	Included
HEMATOLOGIC	DOPTELET	Included	ONCOLOGY - ORAL	ALUNBRIG	Included
HEMATOLOGIC	FIRAZYR	Included	ONCOLOGY - ORAL	BALVERSA	Included
HEMATOLOGIC	HAEGARDA	Included	ONCOLOGY - ORAL	BEXAROTENE	Included
HEMATOLOGIC	MOZOBIL	Included	ONCOLOGY - ORAL	BOSULIF	Included
HEMATOLOGIC	MULPLETA	Included	ONCOLOGY - ORAL	BRAFTOVI	Included
HEMATOLOGIC	PROMACTA	Included	ONCOLOGY - ORAL	CABOMETYX	Included
HEMATOLOGIC	RUCONEST	Included	ONCOLOGY - ORAL	CALQUENCE	Included
HEMATOLOGIC	TAKHZYRO	Included	ONCOLOGY - ORAL	CAPECITABINE	Included
HEMATOLOGIC	TAVALISSE	Included	ONCOLOGY - ORAL	CAPRELSA	Included
HEMOPHILIA - INFUSED	ADVATE	Included	ONCOLOGY - ORAL	COMETRIQ	Included
HEMOPHILIA - INFUSED	ADYNOVATE	Included	ONCOLOGY - ORAL	COPIKTRA	Included
HEMOPHILIA - INFUSED	AFSTYLA	Included	ONCOLOGY - ORAL	COTELLIC	Included
HEMOPHILIA - INFUSED	ALPHANATE/VON WILLEBRAND	Included	ONCOLOGY - ORAL	DAURISMO	Included
HEMOPHILIA - INFUSED	ALPHANINE SD	Included	ONCOLOGY - ORAL	ERIVEDGE	Included
HEMOPHILIA - INFUSED	ALPROLIX	Included	ONCOLOGY - ORAL	ERLEADA	Included
HEMOPHILIA - INFUSED	BEBULIN	Included	ONCOLOGY - ORAL	ETOPOSIDE	Included

HEMOPHILIA - INFUSED	BENEFIX	Included	ONCOLOGY - ORAL	FARYDAK	Included
HEMOPHILIA - INFUSED	COAGADEX	Included	ONCOLOGY - ORAL	GILOTRIF	Included
HEMOPHILIA - INFUSED	CORIFACT	Included	ONCOLOGY - ORAL	GLEEVEC	Included
HEMOPHILIA - INFUSED	ELOCTATE	Included	ONCOLOGY - ORAL	HYCAMTIN	Included
HEMOPHILIA - INFUSED	FEIBA	Included	ONCOLOGY - ORAL	IBRANCE	Included
HEMOPHILIA - INFUSED	HELIXATE FS	Included	ONCOLOGY - ORAL	ICLUSIG	Included
HEMOPHILIA - INFUSED	HEMOFIL M	Included	ONCOLOGY - ORAL	IDHIFA	Included
HEMOPHILIA - INFUSED	HUMATE-P	Included	ONCOLOGY - ORAL	IMATINIB MESYLATE	Included
HEMOPHILIA - INFUSED	IDELVION	Included	ONCOLOGY - ORAL	IMBRUVICA	Included
HEMOPHILIA - INFUSED	IXINITY	Included	ONCOLOGY - ORAL	INLYTA	Included
HEMOPHILIA - INFUSED	JIVI	Included	ONCOLOGY - ORAL	IRESSA	Included
HEMOPHILIA - INFUSED	KOATE	Included	ONCOLOGY - ORAL	JAKAFI	Included
HEMOPHILIA - INFUSED	KOATE-DVI	Included	ONCOLOGY - ORAL	KISQALI	Included
HEMOPHILIA - INFUSED	KOGENATE FS	Included	ONCOLOGY - ORAL	KISQALI FEMARA	Included
HEMOPHILIA - INFUSED	KOVALTRY	Included	ONCOLOGY - ORAL	LENVIMA	Included
HEMOPHILIA - INFUSED	MONOCLATE-P	Included	ONCOLOGY - ORAL	LONSURF	Included
HEMOPHILIA - INFUSED	MONONINE	Included	ONCOLOGY - ORAL	LORBRENA	Included
HEMOPHILIA - INFUSED	NOVOEIGHT	Included	ONCOLOGY - ORAL	LYNPARZA	Included
HEMOPHILIA - INFUSED	NOVOSEVENRT	Included	ONCOLOGY - ORAL	MATULANE	Included
HEMOPHILIA - INFUSED	NUWIQ	Included	ONCOLOGY - ORAL	MEKINIST	Included
HEMOPHILIA - INFUSED	PROFILNINE	Included	ONCOLOGY - ORAL	MEKTOVI	Included
HEMOPHILIA - INFUSED	REBINYN	Included	ONCOLOGY - ORAL	MELPHALAN	Included
HEMOPHILIA - INFUSED	RECOMBINATE	Included	ONCOLOGY - ORAL	MESNEX	Included
HEMOPHILIA - INFUSED	RIXUBIS	Included	ONCOLOGY - ORAL	NERLYNX	Included
HEMOPHILIA - INFUSED	TRETTEN	Included	ONCOLOGY - ORAL	NEXAVAR	Included
HEMOPHILIA - INFUSED	VONVENDI	Included	ONCOLOGY - ORAL	NINLARO	Included
HEMOPHILIA - INFUSED	WILATE	Included	ONCOLOGY - ORAL	ODOMZO	Included

HEMOPHILIA - INFUSED	XYNTHA	Included	ONCOLOGY - ORAL	POMALYST	Included
HEMOPHILIA - INJECTABLE	HEMLIBRA	Included	ONCOLOGY - ORAL	REVLIMID	Included
HEPATITIS B	ADEFOVIR DIPIVOXIL	Included	ONCOLOGY - ORAL	RUBRACA	Included
HEPATITIS B	BARACLUDE	Included	ONCOLOGY - ORAL	RYDAPT	Included
HEPATITIS B	ENTECAVIR	Included	ONCOLOGY - ORAL	SPRYCEL	Included
HEPATITIS B	EPIVIR HBV	Included	ONCOLOGY - ORAL	STIVARGA	Included
HEPATITIS B	HEPSERA	Included	ONCOLOGY - ORAL	SUTENT	Included
HEPATITIS B	LAMIVUDINE HBV	Included	ONCOLOGY - ORAL	TAFINLAR	Included
HEPATITIS B	VEMLIDY	Included	ONCOLOGY - ORAL	TAGRISSO	Included
HEPATITIS C	DAKLINZA	Included	ONCOLOGY - ORAL	TALZENNA	Included
HEPATITIS C	EPCLUSA	Included	ONCOLOGY - ORAL	TARCEVA	Included
HEPATITIS C	HARVONI	Included	ONCOLOGY - ORAL	TARGRETIN	Included
HEPATITIS C	LEDIPASVIR/SOFOSBUVIR	Included	ONCOLOGY - ORAL	TASIGNA	Included
HEPATITIS C	MAVYRET	Included	ONCOLOGY - ORAL	TEMODAR	Included
HEPATITIS C	OLYSIO	Included	ONCOLOGY - ORAL	TEMOZOLOMIDE	Included
HEPATITIS C	PEGASYS	Included	ONCOLOGY - ORAL	THALOMID	Included
HEPATITIS C	PEGINTRON	Included	ONCOLOGY - ORAL	TIBSOVO	Included
HEPATITIS C	SOFOSBUVIR/ VELPATASVIR	Included	ONCOLOGY - ORAL	TRETINOIN	Included
HEPATITIS C	SOVALDI	Included	ONCOLOGY - ORAL	TYKERB	Included
HEPATITIS C	TECHNIVIE	Included	ONCOLOGY - ORAL	VENCLEXTA	Included
HEPATITIS C	VIEKIRA PAK	Included	ONCOLOGY - ORAL	VERZENIO	Included
HEPATITIS C	VIEKIRA XR	Included	ONCOLOGY - ORAL	VITRAKVI	Included
HEPATITIS C	VOSEVI	Included	ONCOLOGY - ORAL	VIZIMPRO	Included
HEPATITIS C	ZEPATIER	Included	ONCOLOGY - ORAL	VOTRIENT	Included
HIV	ABACAVIR	Included	ONCOLOGY - ORAL	XALKORI	Included
HIV	ABACAVIR SULFATE/LAMIVUDINE/ZIDOVUDINE	Included	ONCOLOGY - ORAL	XELODA	Included

HIV	ABACAVIR/LAMIVUDINE	Excluded	ONCOLOGY - ORAL	XOSPATA	Included
HIV	APTIVUS	Excluded	ONCOLOGY - ORAL	XTANDI	Included
HIV	ATAZANAVIR	Excluded	ONCOLOGY - ORAL	YONSA	Included
HIV	ATRIPLA	Excluded	ONCOLOGY - ORAL	ZEJULA	Included
HIV	BIKTARVY	Excluded	ONCOLOGY - ORAL	ZELBORAF	Included
HIV	CIMDUO	Excluded	ONCOLOGY - ORAL	ZOLINZA	Included
HIV	COMBIVIR	Excluded	ONCOLOGY - ORAL	ZYDELIG	Included
HIV	COMPLERA	Excluded	ONCOLOGY - ORAL	ZYKADIA	Included
HIV	CRIXIVAN	Excluded	ONCOLOGY - ORAL	ZYTIGA	Included
HIV	DELSTRIGO	Excluded	ONCOLOGY - TOPICAL	TARGRETIN	Included
HIV	DESCOVY	Excluded	ONCOLOGY - TOPICAL	VALCHLOR	Included
HIV	DIDANOSINE	Excluded	OPHTHALMIC	OXERVATE	Included
HIV	EDURANT	Excluded	OSTEOPOROSIS	FORTEO	Included
HIV	EFAVIRENZ	Excluded	OSTEOPOROSIS	TYMLOS	Included
HIV	EMTRIVA	Excluded	PARKINSONS DISEASE	APOKYN	Included
HIV	EPIVIR	Excluded	PULMONARY DISEASE	ESBRIET	Included
HIV	EPZICOM	Excluded	PULMONARY DISEASE	OFEV	Included
HIV	EVOTAZ	Excluded	PULMONARY HYPERTENSION	ADCIRCA	Included
HIV	FOSAMPRENAVIR	Excluded	PULMONARY HYPERTENSION	ADEMPAS	Included
HIV	FUZEON	Excluded	PULMONARY HYPERTENSION	ALYQ	Included
HIV	GENVOYA	Excluded	PULMONARY HYPERTENSION	LETAIRIS	Included
HIV	INTELENCE	Excluded	PULMONARY HYPERTENSION	OPSUMIT	Included
HIV	INVIRASE	Excluded	PULMONARY HYPERTENSION	ORENITRAM	Included
HIV	ISENTRESS	Excluded	PULMONARY HYPERTENSION	REVATIO	Included
HIV	ISENTRESS HD	Excluded	PULMONARY HYPERTENSION	SILDENAFIL	Included
HIV	JULUCA	Excluded	PULMONARY HYPERTENSION	TADALAFIL	Included
HIV	KALETRA	Excluded	PULMONARY HYPERTENSION	TRACLEER	Included
HIV	LAMIVUDINE	Excluded	PULMONARY HYPERTENSION	TYVASO	Included

HIV	LAMIVUDINE/ ZIDOVUDINE	Excluded	PULMONARY HYPERTENSION	UPTRAVI	Included
HIV	LEXIVA	Excluded	PULMONARY HYPERTENSION	VENTAVIS*	Included
HIV	LOPINAVIR/RITONAVIR	Excluded	TRANSPLANT	ASTAGRAF XL	Included
HIV	NEVIRAPINE	Excluded	TRANSPLANT	CELLCEPT	Included
HIV	NEVIRAPINE ER	Excluded	TRANSPLANT	CYCLOSPORINE	Included
HIV	NORVIR	Excluded	TRANSPLANT	CYCLOSPORINE MODIFIED	Included
HIV	ODEFSEY	Excluded	TRANSPLANT	ENVARSUS XR	Included
HIV	PIFELTRO	Excluded	TRANSPLANT	GENGRAF	Included
HIV	PREZCOBIX	Excluded	TRANSPLANT	MYCOPHENOLATE MOFETIL	Included
HIV	PREZISTA	Excluded	TRANSPLANT	MYCOPHENOLIC ACID DR	Included
HIV	RESCRIPTOR	Excluded	TRANSPLANT	MYFORTIC	Included
HIV	RETROVIR	Excluded	TRANSPLANT	NEORAL	Included
HIV	REYATAZ	Excluded	TRANSPLANT	PROGRAF	Included
HIV	RITONAVIR	Excluded	TRANSPLANT	RAPAMUNE	Included
HIV	SELZENTRY	Excluded	TRANSPLANT	SANDIMMUNE	Included
HIV	STAVUDINE	Excluded	TRANSPLANT	SIROLIMUS	Included
HIV	STRIBILD	Excluded	TRANSPLANT	TACROLIMUS	Included
HIV	SUSTIVA	Excluded	TRANSPLANT	ZORTRESS	Included
HIV	SYMFI	Excluded			
*Includes Nebulizer Generic equivalents may be dispensed in lieu of brands.					

Market Check

Following the initial eighteen month (18) months of the Agreement (but not before), Customer or its designee may provide United a written firm proposal for pharmacy benefit management services offered by a pharmacy benefit management service provider to Customer which takes into account, the aggregate plan design, clinical and trend programs, pharmacy network, specialty pharmacy and mail pharmacy utilization, demographics and other relevant factors for comparable companies (" Customer Current Market Price"). PHM shall have a reasonable opportunity to evaluate the Customer's Current Market Price. If the Customer or its designee conclude that the Customer's Current Market Price would yield an annual two percent (2%) or more savings of the Net Plan Costs (with Net Plan Costs defined as the sum of the cost of Covered Drugs, dispensing fees, and claims administrative fees, less Rebates received by Customer) under the Agreement, and United is unable or unwilling to offer new terms and conditions that would result in savings offered by competing offer, as determined by the Customer or its designee, then Customer may terminate the Agreement upon ninety (90) days' prior written notice to United.

EXHIBIT D – BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("BAA") is incorporated into and made part of the Administrative Services Agreement ("Agreement") between United HealthCare Services, Inc. on behalf of itself and its affiliates ("Business Associate") and City and County of Denver ("Covered Entity") and is effective on January 1, 2020 (Effective Date).

The use of the term Business Associate does not create a joint venture or association, between the Covered Entity and Business Associate, that is in violation of applicable Colorado State, local or Federal law.

The parties hereby agree as follows:

1. DEFINITIONS

1.1 Unless otherwise specified in this BAA, all capitalized terms used in this BAA not otherwise defined have the meanings established for purposes of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations as amended from time to time (collectively, "HIPAA").

1.2 "Privacy Rule" means the federal privacy regulations, as amended from time to time, issued pursuant to HIPAA and codified at 45 C.F.R. Parts 160 and 164 (Subparts A & E).

1.3 "Security Rule" means the federal security regulations, as amended from time to time, issued pursuant to HIPAA and codified at 45 C.F.R. Parts 160 and 164 (Subparts A & C).

1.4 "Services" means, to the extent and only to the extent they involve the receipt, creation, maintenance, transmission, use or disclosure of PHI, the services provided by Business Associate to Covered Entity as set forth in the Agreement, including those set forth in this BAA in Section 4, as amended by written agreement of the parties from time to time.

2. RESPONSIBILITIES OF BUSINESS ASSOCIATE

With regard to its use and/or disclosure of Protected Health Information (PHI), Business Associate agrees to:

2.1 not use and/or disclose PHI except as necessary to provide the Services, as permitted or required by this BAA and/or the Agreement, and in compliance with each applicable requirement of 45 C.F.R. 164.504(e), or as otherwise Required by Law; except that, to the extent Business Associate is to carry out Covered Entity's obligations under the Privacy Rule, Business Associate will comply with the requirements of the Privacy Rule that apply to Covered Entity in the performance of those obligations.

2.2 implement and use appropriate administrative, physical and technical safeguards and comply with applicable Security Rule requirements with respect to Electronic Protected Health Information, to prevent use or disclosure of PHI other than as provided for by this BAA and/or the Agreement.

2.3 without unreasonable delay, report to Covered Entity (i) any use or disclosure of PHI not provided for by this BAA and/or the Agreement, of which it becomes aware in accordance with 45 C.F.R. 164.504(e)(2)(ii)(C); and/or (ii) any Security Incident of which Business Associate becomes aware in accordance with 45 C.F.R. 164.314(a)(2)(i)(C).

2.4 with respect to any use or disclosure of Unsecured PHI not permitted by the Privacy Rule that is caused solely by Business Associate's failure to comply with one or more of its obligations under this BAA, Covered Entity hereby delegates to Business Associate the responsibility for determining when any such incident is a Breach. In the event of a Breach, Business Associate shall (i) provide Covered Entity with written notification, and (ii) provide all legally required notifications to Individuals, HHS and/or the media, on behalf of Covered Entity, in accordance with 45 C.F.R. 164 (Subpart D). Business Associate shall pay for the reasonable and actual costs associated with those notifications.

2.5 in accordance with 45 C.F.R. 164.502(e)(1)(ii) and 45 C.F.R. 164.308(b)(2), ensure that any subcontractors of Business Associate that create, receive, maintain or transmit PHI on behalf of Business Associate agree, in writing, to the same restrictions and conditions on the use and/or disclosure of PHI that apply to Business Associate with respect to that PHI.

2.6 make available its internal practices, books and records relating to the use and disclosure of PHI to the Secretary of HHS for purposes of determining Covered Entity's compliance with the Privacy Rule.

2.7 after receiving a written request from Covered Entity or an Individual, make available an accounting of disclosures of PHI about the Individual, in accordance with 45 C.F.R. 164.528.

2.8 after receiving a written request from Covered Entity or an Individual, provide access to PHI in a Designated Record Set about an Individual, in accordance with the requirements of 45 C.F.R. 164.524.

2.9 after receiving a written request from Covered Entity or an Individual, make PHI in a Designated Record Set about an Individual available for amendment and incorporate any amendments to the PHI, all in accordance with 45 C.F.R. 164.526.

3. RESPONSIBILITIES OF COVERED ENTITY

In addition to any other obligations set forth in the Agreement, including in this BAA, Covered Entity:

3.1 shall provide to Business Associate only the minimum PHI necessary to accomplish the Services.

3.2 shall notify Business Associate of any limitations in the notice of privacy practices of Covered Entity under 45 C.F.R. 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

3.3 shall notify Business Associate of any changes in, or revocation of, the permission by an Individual to use or disclose his or her PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

3.4 shall notify Business Associate of any restriction on the use or disclosure of PHI that Covered Entity has agreed to or is required to abide by under 45 C.F.R. 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

3.5 In the event Covered Entity takes action as described in this Section, Business Associate shall decide which restrictions or limitations it will administer. In addition, if those limitations or revisions materially increase Business Associate's cost of providing Services under the Agreement, including this BAA, Covered Entity shall reimburse Business Associate for such increase in cost, such increase will be limited to those amounts defined in the Master Purchase Agreement as the "Maximum Contract Amount.

4. PERMITTED USES AND DISCLOSURES OF PHI

Unless otherwise limited in this BAA, in addition to any other uses and/or disclosures permitted or required by this BAA or the Agreement, Business Associate may:

4.1 make any and all uses and disclosures of PHI necessary to provide the Services to Covered Entity.

4.2 use and disclose PHI, if necessary, for proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, on the condition that the disclosures are Required by Law or any third party to which Business Associate discloses PHI for those purposes provides written assurances in advance that (i) the information will be held confidentially and used or further disclosed only for the purpose for which it was disclosed to the third party or as Required by Law, and (ii)

the third party promptly will notify Business Associate of any instances of which it becomes aware in which the confidentiality of the information has been breached.

4.3 de-identify PHI received or created by Business Associate under this BAA in accordance with the Privacy Rule.

4.4 provide Data Aggregation services relating to the Health Care Operations of the Covered Entity in accordance with the Privacy Rule.

4.5 use and disclose PHI and data as permitted in 45 C.F.R 164.512 in accordance with the Privacy Rule.

4.6 use PHI to create, use and disclose a Limited Data Set in accordance with the Privacy Rule.

5. TERMINATION

5.1 Termination. If Covered Entity knows of a pattern of activity or practice of the Business Associate that constitutes a material breach or violation of this BAA then the Covered Entity shall provide written notice of the breach or violation to the Business Associate that specifies the nature of the breach or violation. The Business Associate must cure the breach or end the violation on or before thirty (30) days after receipt of the written notice. In the absence of a cure reasonably satisfactory to the Covered Entity within the specified timeframe, or in the event the breach is reasonably incapable of cure, then the Covered Entity may terminate the Agreement and/or this BAA.

5.2 Effect of Termination or Expiration. After the expiration or termination for any reason of the Agreement and/or this BAA, Business Associate shall return or destroy all PHI, if feasible to do so, including all PHI in possession of Business Associate's subcontractors. In the event that Business Associate determines that return or destruction of the PHI is not feasible, Business Associate may retain the PHI and shall extend any and all protections, limitations and restrictions contained in this BAA to Business Associate's use and/or disclosure of any PHI retained after the expiration or termination of the Agreement and/or this BAA, and shall limit any further uses or disclosures solely to the purposes that make return or destruction of the PHI infeasible.

5.3 Cooperation. Each party shall cooperate in good faith in all respects with the other party in connection with any request by a federal or state governmental authority for additional information and documents or any governmental investigation, complaint, action or other inquiry.

6. MISCELLANEOUS

6.1 Construction of Terms. The terms of this BAA to the extent they are unclear shall be construed to allow for compliance by Covered Entity and Business Associate with HIPAA.

6.2 Survival. Sections 5.2, 5.3, 6.1, 6.2, and 6.3 shall survive the expiration or termination for any reason of the Agreement and/or of this BAA.

6.3 No Third Party Beneficiaries. Nothing in this BAA shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

EXHIBIT A-2

EVIDENCE OF INSURANCE PURCHASED
And
ADMINISTRATION SERVICES

Exhibit A-2: **Self-Insured demand deposit form** to be used by United HealthCare Services, Inc., as claims administrator for Denver's self-funded benefit plans, to set up a bank account from which to pay claims and costs as authorized.

PLEASE PROVIDE YOUR GENERAL COMPANY INFORMATION IN THE SPACE PROVIDED

Company Name	City and County of Denver
Company Address	201 W. Colfax Dept 412
Federal Tax ID	84-6000580
Contact Authorized to Sign Banking Letter	Karen Niparko
Contacts Authorized to Receive Information Containing PHI Name, Title, Phone, Email, Address	Heather Britton, Director of Benefits and Wellness, 720.913.5699, heather.britton@denvergov.org Chris O'Brien, Senior Benefit Analyst, 720.913.0748, Christopher.OBrien@denvergov.org Laura Fuentes,Benefit Analyst, 720.913.5636, laura.fuentes@denvergov.org

PLEASE PROVIDE YOUR BENEFIT ACCOUNT INFORMATION IN THE SPACE PROVIDED

Company Name to Appear on Benefits Demand Deposit Account (DDA)	
UnitedHealthcare Insurance Industry relationship Bank	Bank of America
Funding frequency for the Benefits DDA	Select_Here
Funding method for the Benefits DDA	Select_Here
Funding initiator for the Benefits DDA	Select_Here

PLEASE PROVIDE YOUR FUNDING INFORMATION IN THE SPACE PROVIDED

Funding Bank Name	
Funding Bank ABA Number	
Funding Bank Account Number	

PLEASE PROVIDE YOUR REPORT DISTRIBUTION INFORMATION IN THE SPACE PROVIDED

Contacts Authorized to Receive Online Benefits Account Statement Access Contact Information (Limit 2 Contacts) Name, Email	Chris O'Brien, Christopher.OBrien@denvergov.org Laura Fuentes, laura.fuentes@denvergov.org **Note:** Bank of America statement access requires Internet Explorer version 9.0 or newer.
Funding Advice Medium Contact Information Name, Title, Address, Phone, Fax, Email	Select_Here
Daily Charged Claim Activity and Monthly Banking Reports will be available on Employer eServices® Web site. Monthly reporting will post no later than the 5th business day of the following month. Access can be granted by your Client Master Administrator (CMA). Banking Reports are subject to PHI as the standard report option and all users granted banking permission on Employer eServices will have access to these reports.	

CLICK THIS BOX TO UPDATE ALL FIELDS ➔

PLEASE RETURN THE COMPLETED TEMPLATE ALONG WITH ALL ORIGINAL SIGNED DOCUMENTS TO YOUR BANKING ANALYST

UnitedHealthcare
Banking Operations
CityPlace I
185 Asylum St., CT039-03B
Hartford, CT 06103

RE: Benefits Account Establishment Authorization

To Whom It May Concern:

UnitedHealthcare and City and County of Denver have entered into a Self Funded Administrative Service Agreement whereby UnitedHealthcare administers benefits pursuant to the provisions of City and County of Denver's benefits plan. In connection with that agreement, we have requested that, as to City and County of Denver's benefits plan, UnitedHealthcare establish a benefits demand deposit bank account ("DDA") to draw from to pay claims, expenses and other fees at Bank of America into which City and County of Denver will deposit and maintain funds. City and County of Denver is solely responsible for any and all federal, state, local or other governmental demand, charge or tax (by whatever named called) assessed against or imposed upon UnitedHealthcare arising out of UnitedHealthcare's establishing a bank account for City and County of Denver and/or making such payments aforesaid, as agreed by the parties.

The account will be known as:
"UnitedHealthcare Administered Plan for the City and County of Denver"

The benefits DDA will be used to pay benefits, fees and other charges for employees covered under the City and County of Denver's benefits plan. Drafts in payment of these benefits will be drawn by UnitedHealthcare. Expenses paid through the benefits DDA will be those fees and other charges we authorize UnitedHealthcare to collect through this account. The benefits DDA will maintain a minimum required balance as determined by UnitedHealthcare.

Banking Statements should be provided electronically to
Chris O'Brien, Christopher.Obrien@denvergov.org
Laura Fuentes, laura.fuentes@denvergov.org

Physical address for all bank correspondence:
201 W. Colfax Dept 412, Denver, Colorado 80202

Sincerely,

_____ _____

Authorized Signature
Karen Niparko

Dated:

EXHIBIT A
EVIDENCE OF INSURANCE PURCHASED
And
ADMINISTRATION SERVICES

Exhibit A-3: **Self-Funded** benefit plan stop loss insurance policy and application.

UnitedHealthcare Insurance Company

STOP LOSS POLICY

FOR

City and County of Denver

Policy Number: GA-717340AL

Effective Date: January 1, 2020

State or other Jurisdiction of Issue: Colorado

UNITEDHEALTHCARE INSURANCE COMPANY

A Stock Company

185 Asylum Street, Hartford, Connecticut

Phone: 1-860-702-5000

UnitedHealthcare Insurance Company ("Company") agrees to reimburse the Policyholder as outlined under the provisions of this Excess Loss Insurance Policy ("Policy").

This Policy is legally binding between the Policyholder and UnitedHealthcare Insurance Company. The consideration for this Policy includes, but is not limited to, the Application and the Payment of premiums as provided hereinafter.

The Policyholder is entitled to the reimbursement described in this Policy if the Policyholder is eligible for insurance under the provisions of this Policy. Reimbursement is subject to the terms and conditions of this Policy.

The first premium is due on the first (1st) day of the Policy Period. Subsequent monthly premiums are due on the first (1st) day of each month thereafter. The premium is not considered Paid until the Company receives the premium payment.

All periods of coverage will begin and end 12:01 a.m. local time at the principal office of the Policyholder.

This Policy is delivered in and is governed by the laws of the state of issue.

IN WITNESS WHEREOF UnitedHealthcare Insurance Company has caused this Policy to be executed by its President and Secretary.

William J Golden, President

Thomas J. McGuire, Secretary

EXCESS LOSS INSURANCE POLICY

UnitedHealthcare Insurance Company

A Stock Company

185 Asylum Street, Hartford, Connecticut

Phone: 1-860-702-5000

SCHEDULE OF BENEFITS

This Schedule of Benefits is only applicable to Excess Loss Insurance provided by the Company during the Policy Period shown below.

Policyholder: City and County of Denver

Policy Number: GA-717340AL

Effective Date: January 1, 2020

Administrator: United HealthCare Services, Inc.

Coverage specified herein is applicable only during the Policy Period from January 1, 2020 through December 31, 2020, and is further subject to all terms and conditions of this Policy.

SPECIFIC EXCESS LOSS INSURANCE

Benefit Period: Covered Expenses Incurred from January 1, 2020 through December 31, 2020 and Paid from January 1, 2020 through December 31, 2021.

Specific Deductible per Covered Person: $350,000

Specific Percentage Reimbursable: 100%

Maximum Specific Benefit per Covered Person: Unlimited

Specific Excess Loss Insurance includes:

- Medical
- Stand Alone Prescription Drug Program

Specific Excess Loss Premium: $48.11 per subscriber per month

AGGREGATE EXCESS LOSS INSURANCE

Benefit Period: Covered Expenses Incurred from January 1, 2020 through December 31, 2020 and Paid from January 1, 2020 through December 31, 2020.

Aggregate Excess Loss Insurance includes:

- Medical
- Stand Alone Prescription Drug Program

Aggregate Percentage Reimbursable: 100%

Maximum Aggregate Benefit: $2,000,000 per Policy Year

Minimum Annual Aggregate Deductible: $54,244,549 or 95% of the first Monthly Aggregate Deductible amount times 12, whichever is greater

Maximum Covered Expenses per Covered Person accumulating toward the Maximum Aggregate Benefit: $350,000

Monthly Aggregate Factors: $1,200.07 per subscriber

Aggregate Excess Loss Premium: $1.63 per subscriber per month

DEFINITIONS

ADMINISTRATOR means a firm or person who has been retained by the Policyholder to provide administrative services on behalf of the Policyholder/Plan.

ANNUAL AGGREGATE DEDUCTIBLE for any one Policy Period means the greater of: (a) sum of the Monthly Aggregate Deductibles; or (b) the Minimum Annual Aggregate Deductible.

BENEFIT PERIOD means the period of time specified in the Schedule of Benefits in which a Covered Expense must be Incurred by the Covered Person and Paid by the Plan to be eligible for reimbursement under this Policy. This period does not alter the Effective Date, Policy Period, or waive this Policy's eligibility requirements.

COVERED EXPENSE means medical or other expenses under the Plan to which this Policy applies, as shown in the Schedule of Benefits, and which are not specifically excluded by the terms of this Policy. Covered Expense does not include any payment for the cost of administrating the Plan or other Policyholder contracted services.

COVERED PERSON(S) means each person covered under the Plan.

COVERED UNITS(S) means the types of Covered Units and the factors and premium rates for each type as shown in the Schedule of Benefits.

EFFECTIVE DATE is the date set forth in the applicable Schedule of Benefits.

INCURRED means with respect to medical services or supplies, the date on which the services are rendered or supplies are purchased by the Covered Person.

MONTHLY AGGREGATE DEDUCTIBLE means, with respect to a particular month, the total number of Covered Units for that given Policy month multiplied by the corresponding Monthly Aggregate Factors as specified in the Schedule of Benefits.

PAY, PAID, PAYMENT means under the Specific Excess Loss, on the date the Policyholder's check of Payment of a Plan benefit is issued by the Administrator or when a credit of funds for Payment of a Plan benefit has been debited by the Policyholder's bank account. Under the Aggregate Excess Loss, on the date the Policyholder's check for Payment of a Plan benefit has been presented through the collecting bank and reported to the Administrator or when a credit of funds for Payment of a Plan benefit has been debited by the Policyholder's bank account.

PLAN means the self-funded health care plan established by the plan sponsor to provide certain benefits to Covered Persons.

PLAN DOCUMENT means the written document approved by the Policyholder. A copy of the Plan Document in effect on the Effective Date is attached to the application for Excess Loss Insurance.

POLICY PERIOD means the specified period in the Schedule of Benefits, however beginning no earlier than the Effective Date of this Policy and continuing until coverage terminates in accordance with the Termination Provisions.

SPECIFIC DEDUCTIBLE is set forth in the Schedule of Benefits. The Specific Deductible will apply separately to each Benefit Period.

REIMBURSEMENT PROVISIONS

NOTICE OF COVERED EXPENSE The Policyholder authorizes the Administrator to file claims on its behalf under this Policy. The Policyholder authorizes the Company to reimburse Covered Expenses to the Administrator for deposit into the bank account maintained by the Policyholder for the funding of benefits under the Plan.

PAYMENT BY PLAN While the determination of benefits under the Plan is the sole responsibility of the Policyholder, the Company reserves the right to interpret the terms and conditions of the Plan Document as it applies to this Policy. The Company will have the sole authority to reimburse or deny reimbursement under this Policy.

SPECIFIC EXCESS LOSS INSURANCE

The Schedule of Benefits indicates whether Specific Excess Loss Insurance is provided under this Policy. If, while this Policy is in effect, the Covered Expenses for a Covered Person for the applicable Benefit Period exceed the Specific Deductible, the Company will reimburse the Policyholder, subject to the terms and conditions of this Policy including the limits set forth in the Schedule of Benefits.

The amount of the reimbursement will be equal to the Specific Percentage Reimbursable times the amount by which Covered Expenses exceed the Specific Deductible amount, but will not exceed the Maximum Specific Benefit. For purposes of determining whether such Maximum Specific Benefit has been exceeded, Covered Expenses Incurred or Paid in any other Policy Period under this policy are included.

Covered Expenses for any Covered Person during the Policy Period will be determined according to the Benefit Period described in the Schedule of Benefits.

If Specific Excess Loss Insurance terminates before the end of the Policy Period, the Specific Deductible will not be reduced.

AGGREGATE EXCESS LOSS INSURANCE

The Schedule of Benefits indicates whether Aggregate Excess Loss Insurance is provided under this Policy. If the Covered Expenses for the applicable Benefit Period exceed the Annual Aggregate Deductible for the Policy Period, the Company will reimburse the Policyholder, subject to the terms and conditions of this Policy including the limits set forth in the Schedule of Benefits.

The amount of the reimbursement will be equal to the Aggregate Percentage Reimbursable times the amount by which Covered Expenses exceed the Annual Aggregate Deductible amount, but will not exceed the Maximum Aggregate Benefit.

Covered Expenses will not include any amounts reimbursed by the Company under any other provision of this Policy. If the Policyholder's coverage terminates before the end of the Policy Period, the greater of the Accumulated Annual Aggregate Deductible or the Minimum Annual Aggregate Deductible will apply. The Minimum Aggregate Deductible will not be reduced.

PREMIUMS AND FACTORS PROVISIONS

PAYMENT OF PREMIUMS For coverage to remain in effect, any subsequent monthly premium must be received by the Company by the first (1st) day of each month. Premiums are not considered Paid until the Company receives the premium payment. Premiums or other payments made by the Policyholder to their Administrator or Agent or Broker shall not be deemed or considered payments to the Company until actually received by the Company. The entire amount of the applicable premium shall be paid when due. The Company is not obligated to accept or apply any premium paid which is less than the entire amount due for any period. Premium payments shall be credited first to any past due and unpaid premium, in the order in which due.

A late payment charge may be assessed for any premiums not received within thirty-one (31) calendar days following the due date. A service charge will be assessed for any non-sufficient-fund check received in payment of premiums. The Policyholder will reimburse the Company for any attorney's fees and any other costs related to collecting delinquent premiums.

GRACE PERIOD A Grace Period of thirty-one (31) days from the due date will be allowed for the payment of each premium after the first. During the Grace Period, the coverage will remain in effect provided the full premium is Paid before the end of the Grace Period. Should a premium otherwise due, not be Paid during the Grace Period, this Policy will terminate without further notice as of midnight on the last day for which premiums were Paid.

PREMIUM AMOUNT The premiums will be calculated using rates determined by the Company as set forth in the Schedule of Benefits. The amount of total premium due each month is the sum obtained by multiplying the applicable premium rates shown in the Schedule of Benefits by the actual number of appropriate Covered Units.

The Policyholder will be liable for any premium taxes assessed at any time against the Company beyond any taxes which may be payable on the premium received by the Company.

All requests for adjustments, credits or refunds because of overpayment of premiums shall be reported, in writing, with accompanying detail within sixty (60) days after termination of the applicable Policy Period.

The Company will not refund any portion of the premiums Paid if this Policy terminates during this Policy Period. The Company shall be entitled to reduce the reimbursements due the Policyholder under this Policy against any premiums due and unpaid, any overpayments or other reimbursements made in error or upon incorrect information, and any other amounts due the Company.

PREMIUM RATE AND MONTHLY AGGREGATE FACTOR CHANGE The Company may change the Policyholder's premium rates or factors for any of the following:

a) the date when the terms of this Policy are changed;

b) the date the Plan Document changes are accepted by the Company;

c) the date the Policyholder adds or deletes subsidiary or affiliated companies or divisions;

d) the date the number of Covered Units on any premium due date varies more than ten percent (10%) from the number of Covered Units as of the first month of the Policy Period.

TERMINATION PROVISIONS

This Policy and coverage provided hereunder will terminate upon the earliest of:

a) the premium due date of any premium which remains unpaid at the end of the Grace Period;

b) the premium due date next following receipt by the Company of written notice from the Policyholder that this Policy is to be terminated;

c) the date of termination of the Plan;

d) the date the Policyholder suspends active business operations or dissolves;

e) the end of the Policy Period; or

f) the date the administrative services agreement with the Administrator is terminated.

This Policy may also be terminated, at the Company's option on the earliest of:

a) the last day of the second (2nd) consecutive month during which there are less than twenty-five (25) employees enrolled in the Plan, unless the Company agrees, in writing, to continue coverage; or

b) the date the Policyholder fails to comply with the terms of this Policy; or

c) on the Policy anniversary date by the Company giving sixty (60) days advance written notice that this Policy will end, or such other notice as required by law.

The Company will not refund any portion of the premiums paid if this Policy is terminated during the Policy Period.

SUBSEQUENT POLICY PERIOD PROVISIONS

At the end of a Policy Period, this Policy may have a Subsequent Policy Period only by mutual agreement of the Policyholder and the Company and provided that the Company has not given a thirty (30) day termination notice or such other termination notice as required by law. The Subsequent Policy Period may be subject to new premium rates, factors, new underwriting terms, new Benefit Period and other new Policy terms. The terms and conditions for a subsequent Policy Period will be evidenced by the issuance of a new Schedule of Benefits by the Company, which shows the new premium rates, Benefit Period and other new terms.

GENERAL PROVISIONS

ADMINISTRATOR The Policyholder may retain an Administrator to act as an agent for the Policyholder in performing any or all of the duties as designated by the Policyholder. Without waiving any of its rights under this Policy, and without making the designated Administrator a party to this Policy, the Company agrees to recognize the Administrator as an agent of the Policyholder. The Policyholder will immediately notify the Company in writing if the agreement between the Policyholder and the Administrator terminates.

ASSIGNMENT The Policyholder may not assign the Policyholder's interest in or reimbursement under this Policy, and the Company will not recognize any such assignment.

AUDITS The Company will have the right: (a) to inspect and audit all records and procedures of the Policyholder and Administrator, developed and maintained for the Plan, that are applicable to the administration of this Policy; and (b) to require, upon request, proof satisfactory to the Company that Payment has been made to the Covered Person or the provider of such services or benefits which are the basis for any Loss by the Policyholder hereunder.

CHANGES TO THE PLAN DOCUMENT If the Plan Document in effect on the Effective Date is subsequently amended, notice of the amendment will be given to the Company prior to the effective date of the change. If the Company does not give written acceptance of the amendment, the Company will only provide coverage under this Policy consistent with the Plan Document prior to amendment. The Company's reimbursement will be made according to the amended Plan, once the notice is received and accepted.

CHANGES TO THE POLICY Only the President, a Vice President, or the Secretary of the Company have the authority to alter this Policy, or to waive any of the Company's rights and then only in writing. No such alteration of this Policy shall be valid unless endorsed and attached to this Policy. No agent, broker, or Administrator has the authority to alter this Policy or to waive any of its provisions.

CLERICAL ERROR Clerical errors, whether by the Policyholder or by the Company, in keeping or transmitting any records pertaining to the coverage, will not invalidate or limit coverage otherwise validly in force nor continue coverage otherwise validly terminated. Clerical error does not include any failure of the Policyholder, the Administrator or any agent of the Policyholder: (a) to comply with the requirements relating to notice of claims or payment of claims; or (b) to disclose underwriting information requested by the Company, whether or not intentional and regardless of the actual knowledge of the person providing the information.

CONFORMITY WITH LAW If any provision of this Policy is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

ENTIRE CONTRACT The Entire Contract between the Company and the Policyholder will consist of this Policy, Schedule of Benefits, application, approved amendments or endorsements, and a copy of the Plan Document, which is on file with the Company.

INSOLVENCY Nothing in this Policy shall either relieve an insolvent or bankrupt Policyholder from the obligation to pay premiums when due or delay or abate cancellation of this Policy for failure to do so. The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder or the Policyholder's Administrator will not impose upon the Company any liability other than the liability defined in this Policy. In particular, the insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Covered Persons under the Plan.

LEGAL ACTION The Policyholder cannot file suit until ninety (90) days after the date on which proof of loss is given to the Company. The Policyholder cannot file suit more than three (3) years after the date on which the Policyholder must give the Company proof of Loss.

LIABILITY The Company will have neither the right nor the obligation under this Policy to directly pay any Covered Person or provider of professional or medical services. The Company's sole liability is to the Policyholder, subject to the terms and conditions of this Policy. Nothing in this Policy shall be construed to

permit a Covered Person to have a direct right of action against the Company. The Company will not be considered a party to the Plan of the Policyholder, or to any supplement or amendment to it.

MISSTATED DATA, CONCEALMENT, FRAUD The Company has relied on the information provided by the Policyholder, the Administrator or any agent of the Policyholder, in the issuance of this Policy, or for any Subsequent Policy Period. In the event of a misrepresentation, concealment or omission of a fact, or a mistake of fact (whether or not a mutual mistake), any of which materially affect the underwriting, premium, rating or terms and conditions of this Policy, the Company may, at its option:

(a) increase premium rates, attachment points and/or otherwise change the terms and conditions of this Policy. Such increase or change to be effective retroactively to the Effective Date or as of any premium due date thereafter, or

(b) terminate this Policy as of the next premium due date.

The Company may declare this Policy null and void in its inception if, whether before or after a claim, the Policyholder, Administrator or any agent of the Policyholder has willfully or intentionally misrepresented, concealed, omitted any material fact affecting terms, conditions, or underwriting of this Policy. In such event, the Company's liability under this Policy shall be limited to refunding premiums paid by the Policyholder after deducting therefrom the amount of any Covered Expenses reimbursed by the Company to the Policyholder prior to the date of termination. If the amount of the Covered Expenses reimbursed by the Company to the Policyholder exceeds the premiums paid by the Policyholder, the Policyholder shall pay the Company the difference within thirty (30) days of the date the Company notifies the Policyholder of such difference.

NOTICE OF COMPLAINT, APPEAL, LEGAL ACTION As a condition precedent to the Company reimbursing the Policyholder in any settlement or judgment for a disputed Covered Expense, the Policyholder shall immediately inform the Company of any notice of appeal, notice of legal action, or objection, demand or complaint which the Policyholder received regarding any Covered Expense that may be reimburse under this Policy.

OTHER COVERAGE The reimbursement provided by this Policy is in excess of other coverage such as group insurance, excess insurance, insurance, plan benefits, including insurance or plan benefits established by any federal, state, or local law.

PARTIES TO THE POLICY The parties to this Policy are the Policyholder and the Company. The Company's sole liability under this Policy is to the Policyholder. This Policy does not create any right or legal relation between the Company and a Covered Person under the Plan. This Policy will not be deemed to make the Company a party to any agreement between the Policyholder and the Administrator.

POLICYHOLDER REQUIREMENTS The Policyholder agrees to provide funds for Payment of all eligible expenses under the Plan. If the Policyholder fails to provide funds for timely Payment: (a) coverage under this Policy will immediately terminate; and (b) any Aggregate and/or Specific Deductible will be deemed not satisfied.

RECORDS The Policyholder will maintain records of all Covered Persons under the Plan during the Policy Period and for a period of seven (7) years after the end of the Policy Period. The Policyholder will make all such records available to the Company as needed to evaluate its liability under this Policy.

The Policyholder will maintain a separate record of any and all amounts Paid in excess of benefits eligible under the Plan.

SEVERABILITY CLAUSE Any clause deemed void, invalid, or otherwise unenforceable, whether or not such a provision is contrary to public policy, will not render any of the remaining provisions of this Policy invalid.

TERMINATION OF THE POLICYHOLDER'S PLAN The Policyholder will immediately notify the Company, if the Plan is terminated.

THIRD PARTY RECOVERY The Policyholder shall cause the Plan to undertake to pursue any and all valid claims the Plan or a Covered Person may have against third parties arising out of any occurrence resulting in a payment by the Plan or reimbursement by the Company. The Policyholder will account for and pay to the Company any amounts recovered which are reimbursable by the Company to the Policyholder under this Policy, regardless of whether this Policy is still in force on the date of recovery. Third party shall mean a person, entity or insurance company other than the Plan, the Policyholder or a Covered Person. An insurance company shall include insurance companies providing third party liability coverage, or other insurance coverage; i.e. no fault, uninsured, under insured or other similar coverage.

The Policyholder or Administrator shall notify the Company immediately upon discovering that a claim against a third party may exist. Should the Policyholder or the Administrator fail to pursue any valid claims against a third party, the Policyholder shall cause the Plan to assign its subrogation and third party recovery rights to the Company so as to allow the Company to pursue third party recoveries for Covered Expenses reimbursable to the Policyholder. In the event of such assignment, the Company shall have to exercise and enforce all of the Policyholders and/or Plan's rights against such third party. The Policyholder shall furnish such information, assistance, cooperation and execute and deliver such instruments, all as are necessary for the Company to pursue third party recoveries pursuant to this provision.

The Company's right to third party recoveries, as provided for in this provision, shall constitute and impose a trust and first-priority lien arising from any cause of action, settlement, judgment or arbitration award against a third party.

The Policyholder shall pay the Company all amounts recovered, whether by suit, settlement, alternative dispute resolution, including but not limited to arbitration or mediation, or otherwise, from any third party or their insurer to the extent of Covered Expenses regardless of whether such recovery shall be a full or partial recovery. If a third party recovery received by the Plan or Policyholder is less than the total amount paid by the Plan on behalf of the Covered Person, the Company shall be entitled to recover first, in full, any Covered Expense reimbursed by the Company under this Policy. The Company's recovery shall not be reduced by any attorney's fees incurred by the Policyholder, Plan or Covered Person unless the Company otherwise agrees in writing. All remaining amounts shall be paid to the Policyholder.

The Policyholder's failure to comply with this provision may result in the denial of a Covered Expense, in addition to all other rights of the Company under this Policy.

WAIVER Failure of the Company to strictly enforce its rights under this Policy shall not waive any such right, regardless of the frequency or similarity of the circumstances.

GENERAL EXCLUSIONS PROVISIONS

The Company will not reimburse the Policyholder for any of the following:

(a) Any payment which does not strictly comply with the terms and conditions of the Plan Document;

(b) Any payment or expense caused by or resulting from war, declared or undeclared or international armed conflict;

(c) Any payment for litigation costs and expenses, extra-contractual damages, compensatory damages, interest, exemplary and punitive damages or liabilities, including but not limited to those resulting from negligence, intentional wrongs, fraud, bad faith or strict liability on the part of the Policyholder, Plan, Administrator or any agent or representative of the Policyholder, Plan or Administrator;

(d) Any payment for occupational accidents or illnesses which are also eligible expenses covered by Workers' Compensation or Occupational Disease law, or similar legislation, whether or not coverage under such law is actually in force.

UNITEDHEALTHCARE INSURANCE COMPANY

A Stock Company

185 Asylum Street, Hartford, Connecticut

Phone: 1-860-702-5000

APPLICATION FOR EXCESS LOSS INSURANCE

The undersigned Applicant requests the Excess Loss Insurance Benefits shown herein and provided by UnitedHealthcare Insurance Company, and agrees to be bound by the terms and provisions of the Excess Loss Insurance Policy.

Full Legal Name of Applicant: City and County of Denver
Address: 201 W. Colfax Dept. 412, Denver, CO 80202
Key Contact: Heather Britton **Telephone:** (720) 913-5697 **Tax ID:** 84-6000580

Applicant is a: Municipality
Nature of Business of the Group to be Insured: City Government **Requested Effective Date:** January 1, 2020

Total number of eligible persons: Employees, their Dependents and Retirees: 8373 **Retirees:** (339 included in total population)
Are retirees covered: Y

Agent or Broker: Lockton Companies
SS No. or Tax ID: 20-3354970
Address: 8110 E. Union Ave., Suite 700, Denver, CO 80237

SPECIFIC EXCESS LOSS INSURANCE:

Benefit Period: Covered Expenses Incurred from January 1, 2020 through December 31, 2020, and Paid from January 1, 2020 through December 31, 2021.

Specific Deductible per Covered Person: $350,000
Specific Percentage Reimbursable: 100%
Maximum Specific Benefit per Covered Person: Unlimited

Covered Expenses Under Specific Excess Loss:

- Medical
- Stand Alone Prescription Drug Program

Specific Excess Loss Premium: $48.11 per subscriber per month

AGGREGATE EXCESS LOSS INSURANCE

Benefit Period: Covered Expenses Incurred from January 1, 2020 through December 31, 2020, and Paid from January 1, 2020 through December 31, 2020.

Covered Expenses under Aggregate Excess Loss Coverage:

- Medical
- Stand Alone Prescription Drug Program

Aggregate Percentage Reimbursable: 100%

Maximum Aggregate Benefit: $2,000,000 per Policy Year

Minimum Annual Aggregate Deductible: $54,244,549 or 95% of the first Monthly Aggregate Deductible amount times 12, whichever is greater.

Maximum Covered Expenses per Covered Person accumulating toward the Maximum Aggregate Benefit: $350,000

Monthly Aggregate Factors: $1,200.07 per subscriber

Aggregate Excess Loss Premium: $1.63 per subscriber per month

It is understood and agreed by the undersigned that:

a. The statements, declarations and representations made in this Application, any request for proposal, the underwriting information provided by or on behalf of the undersigned and the Plan Document are the undersigned's representations; that any Policy is issued in reliance upon the truth of such statements, declarations, and representations; and that such statements, declarations, and representations will form a part of the Excess Loss Insurance Policy. Any inaccuracy in such information or failure to disclose any such information, including all claims or possible claims, paid or pending, or which the Employer should otherwise know about, if discovered later, can result in rejection of this Application, or can change the terms, conditions or premiums, or can void coverage.

b. As a condition precedent to the approval of this Application, the undersigned shall furnish to the Company a copy of the executed Plan Document within 90 days after the date of this application describing the benefits provided by the Plan, which shall be kept on file in the office of the Company. If the Company does not receive the Plan Document within 90 days, the Company may refund all premium and the Application shall have been null and void when signed. No Excess Loss Insurance will be effective nor reimbursement made unless a Plan Document is received and accepted by the Company.

c. The Company will evaluate the undersigned's risk, as requested by this application, the underwriting data received and represented by the Plan and may require adjustments of rates, factors, and/or special limitations.

d. Any coverage resulting from this Application shall be subject to the terms and provisions of the Policy herein applied for. Coverage shall become effective on the date specified in this Application if all requirements of the Company, including the Plan Document and the underwriting requirements have been met and the required premiums paid.

e. The receipt by the Company of the first month's premium and deposit of any check drawn in connection with this Application shall not constitute an acceptance of liability. In the event the Company does not approve this application, its sole obligation shall be to refund such sum to the undersigned.

The undersigned has read the entire Application for Excess Loss Insurance and understands that the insurance requested herein is not in effect until this Application is approved and accepted by the Company.

Full Legal Name of Applicant:	
Signature of Authorized Person:	
Print Name:	Title:
Date:	
Signature of Agent or Broker:	
Print Name of Agent or Broker: Lenard Tucker	

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For applicants in Arkansas and Louisiana:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

For applicants in Colorado:

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

For applicants in District of Columbia:

WARNING: It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.

For applicants in Florida:

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

For applicants in Kentucky, New Mexico, Ohio, and Pennsylvania:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For applicants in Maine, Tennessee and Virginia:

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

For applicants in New Jersey:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For applicants in all other states:

If is a crime to knowingly provided false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

EXHIBIT A-4
TO
EVIDENCE OF INSURANCE PURCHASED
And
ADMINISTRATION SERVICES

Exhibit A-4: New York State Required Documents for Self-Funded HSA Plan

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL
DOH-4264 INSTRUCTIONS

All electing payors/third party administrators (TPA)/administrative services only (ASO) organizations and designated providers are required to file Public Goods Pool reports electronically. This also applies to the 1% Statewide Assessment report filed by hospitals. To file electronically, you must establish an electronic filing account and be assigned a secure password. A website has been established at www.hcrapools.org to facilitate this process.

While electronic filing is designed to be user friendly, a help desk has been established to aid those users requiring assistance. If you need general assistance or assistance in obtaining copies of the electronic filing screens and the electronic reporting certification forms, please contact the help desk at (315) 671-3800 or via e-mail at webpools@hcrapools.org.

Upon receipt of a fully completed Electronic Filing User ID Application (DOH-4264), the Office of Pool Administration will assign a secure electronic filing user ID and password to your organization, which you will receive via return mail.

New Request/Revision to Existing Account: Check the appropriate box. An entity requesting an initial account/password should check the *New Request* box; an entity that has an existing account and is advising the Department of a change to that account should check the *Revision to Existing Account* box.

Payor/TPA/ASO/Provider Name: Enter name of entity that may use the OPA website.

Federal Employer Identification Number (FEIN): Enter FEIN assigned to the entity named above.

Operating Certificate #: (For providers only): Enter Operating Certificate number assigned by the Department of Health to the entity named above.

Report(s) being filed electronically (check ALL applicable types): Check all applicable types of reports that your entity will be filing electronically – Public Goods Pool and/or Statewide Assessment.

Signature: Must be signed by the Chief Executive/Financial Officer and/or Administrator of the entity named above.

Name/Title/Phone Number (Please Print): Enter name, title and phone number of the person signing above.

Address/City/State/Zip Code: Enter address of the person signing above.

E-mail Address: Enter e-mail address of the person signing above. This email address will be used to communicate Health Care Reform Act information, including delinquency reporting notifications and periodic legislative updates.

Date: Enter date this form is signed.

Electronic Filing User ID Application

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

X New Request **□ Revision to Existing Account**

Payor (Customer Name is Payor)/Third Party Administrator/Administrative Services Only Organization/Provider

Name: _____

Federal Employer Identification # (FEIN): _____

Operating Certificate # (FOR PROVIDERS ONLY): N/A

Report(s) being filed electronically (check ALL that apply):

- **X** Public Goods Pool
- □ 1% Statewide Assessment **(for hospitals only)**

By signature below, the Chief Financial Officer or other duly authorized individual of the above named entity authorizes the Office of Pool Administration to assign a secure electronic filing user ID and password to the entity. This information will be mailed directly to the attention of the signer and must remain secured. If an email address is provided, this information will be sent electronically to the email address listed. It is the responsibility of the above named entity to ensure that this information is released only to those individuals requiring knowledge thereof.

Signature _____

Name (Please Print) _____

Title _____

Phone Number _____

Address _____

_____

City _____ **State** _____ **Zip Code** _____

E-mail Address _____

Date _____

Please mail completed form to:
Mr. Jerome Alaimo, Pool Administrator
Office of Pool Administration
Excellus BlueCross BlueShield, Central New York Region
P.O. Box 4757
Syracuse, New York 13221-4757

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL
DOH-4399 INSTRUCTIONS

A payor voluntarily electing to make public goods payments directly to the Office of Pool Administration must complete forms DOH-4399 (Payor Election Application) and DOH-4264 (Electronic Filing User ID Application).

Instructions for pages 1 and 2:

Effective Date: Enter effective date of election. Note: An election application received from any payor or organization shall begin on the first day of the month following the date it was received by the Office of Pool Administration unless a future date is specified.

Federal Employer Identification # (FEIN): Enter federal employer identification number (FEIN) of the payor. Please note that Section 2807-j(5)(a)(iii)(D) of the Public Health Law requires the New York State Department of Health to publish the FEIN of all electing payors on a secure website.

Payor Name: Enter name of payor. The payor name is that of the incorporated entity, local government, self-insured fund.

D/B/As: Enter any assumed name(s) ("d/b/a") under which the entity is doing business.

Address: Enter address of payor.

Contact Person: Enter name of contact person that will be responsible for providing the Department with the information regarding the payor's election, lines of business and claims processing.

Phone #: Enter phone number of the contact person.

E-Mail Address: Enter the e-mail address of the contact person.

If the election submission is for a payor that is utilizing a third-party administrator (TPA)/administrative services only (ASO) for claims processing, the following information must also be provided. If more than one TPA/ASO is utilized, attach a list of additional TPAs/ASOs.

TPA/ASO Name: Enter name of the TPA/ASO representing said payor.

TPA/ASO FEIN: Enter FEIN of the TPA/ASO.

The Signature of the chief financial officer or other duly authorized individual binds the payor to make direct pool payments for all its public goods funding obligations, file reports and remit funds in conformance with the Health Care Reform Act (HCRA) provisions and Department requirements, and represents an agreement as to the jurisdiction of the State for purposes of enforcing payments required under Public Health Law sections 2807-j and 2807-t. This does not, in any way, preclude a payor from litigating other issues in Federal court such as ERISA based challenges, etc.

Instructions for page 3:

This form must be completed by all payors making an election and represents a payor's attestation of the coverage it provides. A payor electing to pay the Department's Office of Pool Administration directly is making an election for all its coverages for which it assumes risk for the payment of medical claims. Payors utilizing multiple third-party administrators (TPA)/administrative services only (ASO) organizations must complete a Coverage Information form for each TPA/ASO.

- In each payor category which applies, the payor should mark an "X" in each column to indicate that the payor provides such coverage. Each box marked with an "X" represents the coverages that it assumes risk for. As stated before, a payor is required to elect for all coverages for which it assumes risk for the payment of medical claims. Shaded areas should not be checked.

- If an Article 43 NYS Insurance Law corporation or licensed commercial insurer has a separate incorporation for its Article 44 NYS Public Health Law business, that corporation must check the appropriate boxes on a single election form. Otherwise, the Article 44 NYS Public Health Law business is considered to be a product line of the Article 43 or commercial payor and the payor is required to make a single election for this and all other types of coverage provided by the corporation. A payor, who does not fall into any of the categories listed, should check "Other" in the payor identification section and explain their payor type in the space provided.

Please mail completed election application (DOH-4399 and DOH-4264) to:
Mr. Jerome Alaimo, Pool Administrator
Office of Pool Administration
Excellus BlueCross BlueShield, Central New York Region
P.O. Box 4757
Syracuse, New York 13221-4757

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

Effective Date: _____

FEDERAL EMPLOYER IDENTIFICATION # (FEIN): _____

PAYOR NAME: _____

D/B/As (IF APPLICABLE): _____

ADDRESS: _____

_____

CONTACT PERSON: _____

PHONE #: _____

E-MAIL ADDRESS: _____

If the above referenced entity is a payor that utilizes a third-party administrator (TPA)/administrative services only (ASO) for claims processing, please provide the following information:

TPA/ASO NAME: **UnitedHealthcare Inc.**

TPA/ASO FEIN: **41-1289245**

By signature below, the above entity elects to make all public goods surcharge payments directly to the Office of Pool Administration for all its coverages for which it assumes risk for the payment of medical claims and agrees to:

1. remit to the Department's Office of Pool Administration required surcharge payments for all applicable services on a monthly basis on or before the 30th day following the calendar month for which monies have been paid to designated providers of service;

2. provide the Department's Office of Pool Administration monthly certified reports on or before the 30th day following the calendar month for which monies have been paid which separately report patient service expenditures for services provided by designated provider type(s) (i.e., hospital inpatient, hospital outpatient, diagnostic & treatment center, laboratory[1], or ambulatory surgery center) by product line;

3. provide the Department with certification of data and access to allowance expenditure data upon request for audit verification purposes; and

[1]For services provided on or after October 1, 2000, freestanding clinical laboratories with Article 5 Title V permits are exempt from HCRA surcharges.

4. the jurisdiction of the state to maintain an action in the courts of the State of New York to enforce any provision of section 2807-j of the Public Health Law (see note below).

5. the Department's website posting of the above entity's FEIN in accordance with Public Health Law Section 2807-j(5)(a)(iii)(D).

By signature below, the above entity also agrees to make public goods covered lives payments directly to the Department's Office of Pool Administration in instances where it provides inpatient coverage as a corporation organized and operating in accordance with Article 43 of the Insurance Law, an organization operating in accordance with Article 44 of the Public Health Law, a self-insured fund, or an HMO or insurer licensed outside New York State and authorized to write accident and health insurance and whose policy provides inpatient coverage on an expense incurred basis. In such instances the above entity agrees to:

1. remit to the Department's Office of Pool Administration within 30 days after the end of each month one-twelfth of both the individual and family unit annual assessment amounts for each of the individuals and family units residing in the state which were included on the payor's membership rolls for all or a portion of the prior month and for which the payor covered general hospital inpatient care, including retroactive additions and deletions;

2. provide the Department with data certification and access to individual and family unit data, upon request, for audit verification purposes; and

3. the jurisdiction of the state to maintain an action in the courts of the State of New York to enforce any provision of section 2807-t of the Public Health Law (see note below).

By signature below, the Chief Financial Officer or other duly authorized individual of the above entity certifies that the data submitted on all applicable attachments have been carefully prepared in accordance with instructions provided, and to the best of his/her knowledge, the information presented is accurate and correct.

Signature_____ **Title**_____
Chief Financial Officer or Duly Authorized Individual

Date_____

Note: Payors making an election are only agreeing to the jurisdiction of NYS courts for purposes of enforcing payments required under 2807-j and 2807-t. This does not, in any way, preclude a payor from litigating other issues in Federal court such as ERISA based challenges, etc.

Payor Election Application

COVERAGE INFORMATION (See Attached For Further Explanation)

PAYOR NAME: _____ **FEDERAL ID#:** _____

TPA/ASO NAME: UnitedHealthcare Inc. **TPA/ASO FEDERAL ID#:** 41-1289245

MARK AN "X" IN EACH COLUMN TO INDICATE TYPE OF COVERAGE BY PAYOR TYPE

	TYPE OF PAYOR:	IDENTIFICATION OF TYPE OF COVERAGE:									
		INDEMNITY COVERAGE	HMO NON-MEDICAID OR NON-NYS MEDICAID COVERAGE	SELF-INSURED COVERAGE	NEW YORK STATE HMO/PHSP MEDICAID COVERAGE	NEW YORK STATE GOVT PROGRAM W/INPATIENT COMPONENT & NYS LOCAL GOVT CORRECTIONS	NEW YORK STATE WORKERS COMPENSATION LAW COVERAGE	NEW YORK STATE MOTOR VEHICLE REPARATIONS ACT COVERAGE	NEW YORK STATE VOLUNTEER AMBULANCE WORKER'S BENEFIT LAW COVERAGE	NEW YORK STATE VOLUNTEER FIREFIGHTERS' BENEFIT LAW COVERAGE	OTHER COVERAGE
1	Corporations Organized & Operating in accordance with Article 43 of the NYS Insurance Law										
2	Corporations that are Commercial Insurers licensed in New York State										
3	Corporations Organized & Operating in accordance with Article 44 of the NYS Public Health Law, not incorporated as Commercial Insurers or under Article 43 of the NYS Insurance Law										
4	Self-Insured Fund with No Third Party Administrator/Administrative Svcs Only Organization for Claims Processing										
5	Self-Insured Fund with a Third Party Administrator/Administrative Svcs Only Organization for Claims Processing			X							
6	New York State Governmental Agency/ New York State Local Government										
7	Other (please explain below): Includes: State/Local Governments outside New York for Medical Assistance Programs; insurers licensed outside New York State, authorized to write OTHER than Accident and Health										
8	HMOs and insurers licensed outside New York State, authorized to write Accident and Health										

Explanation of "Other" Payor Identification

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL
COVERAGE INFORMATION

Payor Type 1: Corporation organized and operating in accordance with Article 43 of the New York State Insurance Law offering:

→ Indemnity Coverage with an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident insureds

→ Indemnity Coverage without an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

→ HMO non-Medicaid managed care coverage, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident non-Medicaid insureds

→ HMO Medicaid managed care coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident Medicaid managed care enrollees

Payor Type 2: Commercial Insurance Corporation licensed by New York State offering:

→ Indemnity Coverage with an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident insureds

→ Indemnity Coverage without an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

→ HMO non-Medicaid managed care coverage, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident non-Medicaid insureds

→ HMO Medicaid managed care coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident Medicaid insureds

→ New York State Workers Compensation Law coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

→ New York State Motor Vehicles Reparations Act coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

→ New York State Volunteer Ambulance Workers Benefit Law coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

→ New York State Volunteer Firefighters Benefit Law coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

Payor Type 3: Corporation organized and operating in accordance with Article 44 of the New York State Public Health Law not incorporated as a NYS licensed commercial insurer or under Article 43 of the New York State Insurance Law offering:

→ HMO non-Medicaid managed care coverage, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident non-Medicaid managed care enrollees

→ HMO Medicaid managed care coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident Medicaid managed care enrollees

Payor Type 4/5: Self insured fund offering:

→ self insured employee health coverage with an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services and regional GME covered lives assessments for NYS resident plan participants

→ self insured employee health coverage without an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident plan participants

→ self insured New York State Workers Compensation Law coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident plan participants

→ self insured **non-New York State** Workers Compensation Law coverage, thus requiring a surcharge obligation on affected services and a regional GME covered lives assessments (if coverage includes expense incurred inpatient hospital care) for NYS resident plan participants

→ self insured New York State Motor Vehicles Reparation Act coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident plan participants

→ self insured **non-New York State** Motor Vehicles Reparations Act coverage, thus requiring a surcharge obligation on affected services and a regional GME covered lives assessments (if coverage includes expense incurred inpatient hospital care) for NYS resident plan participants

Payor Type 6: New York State Governmental Agency/ New York State Local Government:

→ New York State political subdivision for New York State county corrections, New York City corrections, and, New York State governmental agencies for New York State administered payments that reimburse hospitals for rendered inpatient services to eligible patients. (e.g. Office of Mental Health payments for services provided to individuals residing in New York State operated developmental centers), thus requiring a surcharge obligation on affected services but no regional GME covered lives assessment

Payor Type 7: Other

→ Insurers **licensed outside New York State, authorized to write OTHER than Accident and Health** thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

→ States **other than New York State** and localities **other than New York State political subdivisions** for medical assistance program expenses (i.e. Medicaid Programs in states OTHER than New York State), thus requiring a surcharge obligation on affected services but no regional GME covered lives assessment

→ NYS licensed fraternal benefit societies offering coverage with or without an expense incurred inpatient hospital component, requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

Payor Type 8: HMOs and insurers licensed outside New York State, authorized to write Accident and Health:

→ Indemnity Coverage with an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident insureds

→ Indemnity Coverage without an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

→ HMOs **organized and operating outside New York State Insurance and Public Health Laws**, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident insureds