ADMINISTRATIVE SERVICES AGREEMENT

DATE:	August 20, 2024	
PARTIES:	City of Everett 2930 Wetmore Ave, Suite 5-A Everett, WA 98201	the "Plan Sponsor"
	Healthcare Management Administrators, Inc. 10700 Northup Way, Suite 100 Bellevue, WA 98004	"HMA"
Effective Date:	January 1, 2025	

Recitals:

A. Plan Sponsor has established a self-insured Employee Welfare Benefit Plan (the "Plan"), as defined in the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, for the purpose of providing certain benefits to its eligible employees and their dependents ("Participants");

B. Plan Sponsor desires to retain HMA to furnish claims processing and other ministerial services with respect to the Plan; and

C. HMA is willing to furnish such services, based upon the terms and conditions set forth in this Administrative Services Agreement (the "Agreement").

NOW, THEREFORE, in consideration of the mutual covenants and conditions contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, and intending to be legally bound hereby, Plan Sponsor and HMA agree as follows:

Agreement:

1. **Definitions.** As used in this Agreement, the following terms shall have the following meanings:

   (a) "Effective Date" means the day and year set forth above, which shall be the date this Agreement becomes effective.

   (b) "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

   (c) "Participants" means those employees of the Plan Sponsor, and their dependents, or other individuals who have met the eligibility requirements of the Plan, have satisfied all other conditions to participation in the Plan, and are properly enrolled in and eligible for benefits under the Plan.

   (d) "Plan Administrator" means the person or organization responsible for the functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services. If

a Plan Administrator is not appointed in the Plan Document, then the Plan Administrator is the Plan Sponsor.

2. **Relationship of Parties.**

(a) **HMA Acting In Ministerial Capacity.** The parties acknowledge and agree that HMA is acting solely in a ministerial capacity in performing its duties and obligations under this Agreement and shall have no discretionary authority or responsibility with respect to the administration of the Plan. HMA shall have no power to interpret ambiguities or conflicts that may exist in any provision of the Plan, but shall abide by the decisions of the Plan Administrator on all questions of substance and procedure respecting the Plan. HMA does not insure nor underwrite the liability of the Plan Sponsor under the Plan and shall have no financial risk or liability with respect to the provision of benefits under the Plan. As such, HMA shall not be deemed a "fiduciary" of the Plan within the meaning of ERISA.

(b) **Plan Administrator and Named Fiduciary.** The parties agree that Plan Sponsor is, and shall at all times remain, the Plan Administrator and the Named Fiduciary (as defined in ERISA) for purposes of ERISA. The Plan Administrator shall oversee the administration of the Plan and be responsible for complying with all reporting and disclosure requirements of ERISA; shall have the exclusive right to interpret the terms of the Plan and to determine eligibility for coverage and benefits, which determination shall be conclusive and binding on all persons; and shall have final authority with respect to approval or disapproval of any disputed or doubtful claim.

HMA is not a fiduciary with respect to this engagement and shall not exercise any discretionary authority or control over the management or administration of the Plan, or the management or disposition of the Plan's assets. HMA shall limit its activities to carrying out ministerial acts of notifying Plan Participants and making benefit payments as required by the Plan. Any matters for which discretion is required, including, but not limited to, decisions on claims and appeals of denied claims, shall be referred by HMA to the Plan Administrator, and HMA shall take direction from the Plan Administrator in all such matters. HMA shall not be responsible for advising the Plan Administrator with respect to its fiduciary responsibilities under the Plan nor for making any recommendations with respect to the investment of Plan assets. HMA may rely on all information provided to it by the Plan Sponsor, as well as the Plan's other vendors. HMA shall not be responsible for determining the existence of Plan assets.

(c) **Independent Contractor Relationship.** Notwithstanding anything express or implied in this Agreement to the contrary, the parties acknowledge and agree that HMA is acting as an independent contractor, and for all purposes shall be deemed to be an independent contractor in performing its duties, and fulfilling its obligations, under this Agreement. Neither HMA, nor any individual performing services on its behalf, shall be considered or construed to have created an employee/employer relationship with Plan Sponsor for any purpose whatsoever.

3. **Services to be Provided by HMA.**

(a) **Summary Plan Description Services.** Upon request, HMA shall prepare a Summary Plan Description (SPD) setting forth the benefits and rights of the Plan Participants under the Plan Sponsor's plan. Final review and approval of the

SPD will be the responsibility of the Plan Administrator. The preparation of any Summaries of Material Modifications, along with the distribution of the SPD and any amendments is the responsibility of the Plan Administrator. Document translation support and printing/distribution fulfillment support is available upon request for additional fees that will be quoted at the time requested. HMA shall assist the Plan Administrator in communicating to Participants any and all subsequent changes to the Plan approved by Plan Sponsor.

(b) **Open Enrollment Materials Services.** Upon request HMA shall prepare and assist the Plan Administrator in distributing benefit booklets to the Plan Participants. Initial booklet supply is not included as a part of the Plan set-up fee. Subsequent supplies are also at the Plan Sponsor's cost.

(c) **Claims Processing Services.**

Subject to the provisions of Section 2, HMA agrees to provide the following claims processing and payment processing services, including, but not limited to:

(i) Answer telephone inquiries from employees of Plan Sponsor regarding eligibility and coverage under the Plan and respond to requests for forms and status inquiries on filed claims and benefit payments. HMA will provide adequate customer service representatives between the hours of 6:00 a.m. to 6:00 p.m. PST, Monday thru Friday, during non-holiday workweeks.

(ii) Receive and process claims for payment of covered benefits for Plan Participants in accordance with the provisions of the Plan, for claims incurred on and after the Effective Date of this Agreement.

(iii) Communicate with Plan Participants and health care providers as necessary to obtain additional information deemed necessary to process benefit claims.

(iv) Request and obtain from the Plan Administrator, as necessary, interpretations with respect to the provisions of the Plan and other guidance as necessary for adjudication of claims.

(v) Issue and distribute claims payments to providers and/or Participants, from funds provided by the Plan Sponsor, and provide appropriate Explanation of Benefit forms ("EOB's") to Plan Participants and health care providers, as applicable.

(vi) Provide appropriate written notice to a Plan Participant and the provider of claim denial and the opportunity for review of the denial.

(vii) Provide Plan Administrator with information and supporting documentation associated with a member initiated second level appeal to allow the Plan to render a determination on the appeal. In the event that the Plan has purchased Claim Fiduciary Services, this provision shall not apply.

(viii) Make available to plan participants and providers claim submission forms for use by Plan Participants in submitting claims to HMA.

(ix) Apply payment integrity programs and services as outlined in the Claims administrative Fees and/or Client Intent documents. Such programs and

services include, but are not limited to, coordination of benefits activities, facility and coding review on eligible claims as per our internal thresholds, medical necessity reviews, subrogation and other collection activities, and collection of overpayments or improper payments made to any Participants, as reasonably possible. HMA shall perform the necessary services with respect to obtaining recoveries, including, but not limited to fraud, waste, and abuse claim review services, third party claim recovery/overpayment recovery services, sending questionnaires, providing and receiving documentation, as applicable. HMA has the discretion to utilize the services of a third-party in connection with such matters. Plan Sponsor acknowledges that waiver or reduction of a recovery may be necessary as a result of the particular facts or law applicable to the recovery. HMA shall refer requests for negotiation or waiver of a claim to the Plan Sponsor for final determination. There may be fees for these services as outlined in the Claim Administrative Fee Schedule and/or the Client Intent. In the event that additional recovery services are needed, HMA, subject to the approval of the Plan Sponsor, shall arrange for the purchase of such recovery services. Any fees charged to HMA for recovery services will be passed on to the Plan Sponsor for payment. HMA reserves the right to retain a nominal percentage of the net recovery to the Plan Sponsor to compensate HMA for increased administrative fees associated with recovery services.

(x) Screen claims to avoid duplicate payments and maintain procedures that facilitate consistency in claims processing in accordance with the Plan.

(xi) Prepare such reports concerning Plan Participants' benefits as the Plan Sponsor, the Plan Administrator and HMA may hereafter agree upon.

(xii) HMA shall coordinate for the approval of claims for payment by the Plan Sponsor. Once Plan Sponsor has approved the claims via issuing the requested funding then HMA shall pay from the Plan Sponsor bank account, if provided, or shall issue an order to the Plan Sponsor or other person with authority to disburse funds of the Plan Sponsor to pay the expenses of operation of the Plan incurred pursuant to the performance of this Agreement (excluding Plan administration fees unless specifically authorized)HMA shall honor any assignment of benefits of a person eligible for benefits under Plan to any person or institution, which is a proper and qualified assignee if applicable under the terms of the Plan.

(d) **Initial Transition services.**

When the Plan Administrator desires that HMA begin performance under this Agreement prior to completion and execution of a restated SPD, HMA shall perform claims processing in accordance with the Plan Sponsor's existing SPD. In no event will HMA process any claims on a "run-in" basis. Nor will claims be processed utilizing a prior carrier/administrator's network discounts. All claims will be adjudicated in accordance with the terms of the network(s) accessed through HMA. The Plan Sponsor hereby acknowledges that any claims which require reprocessing as a result of changes between the prior SPD or the Plan Sponsor's instructions and the restated executed SPD will be subject to an additional reprocessing fee at HMA's discretion. The Plan Sponsor further acknowledges that claims which are paid pursuant to the benefits and exclusions described within the

prior SPD or the Plan Sponsor's instructions, may be determined to be ineligible for reimbursement pursuant to any excess loss policy.

(e) **Transparency Regulation Support.**

To the extent the Plan is obligated under 26 CFR Part 54 [TD 9929], 29 CFR Part 2590, and 45 CFR Parts 147 and 158 (the "Transparency Regulations") to make filings or obtain approval from any state or other jurisdictional governing agency, HMA will notify and assist the Plan regarding such filings. Subject to the limitation described below, HMA agrees to provide, on behalf of the Plan, all publications of information and disclosures (collectively, "the Disclosures") necessitated by the price transparency requirements set forth in the Transparency Regulations and the Consolidated Appropriations Act of 2021 Divisions BB and EE, amending the Public Health Service Act, the Internal Revenue Code, and the Employee Retirement Income Security Act ("CAA Transparency Provisions"). Notwithstanding the foregoing, HMA shall have no obligation to make the Disclosures with respect to benefits or services for which HMA is not supporting the Plan (i.e. dialysis carve-outs and Pharmacy services, except those covered under an HMA partner Pharmacy Benefit Manager Contract). HMA shall exercise in its sole discretion in interpreting the applicable federal standards for the Disclosures on behalf of the Plan pursuant to the Transparency Regulations and CAA Transparency Provisions. Under no circumstances shall HMA be liable for the direct or indirect payment of Plan benefits, regardless of fault.

(f) **HB 1065 & No Surprises Act/IDR Balance Billing Support.**

If the Plan files directly with the State to Opt-in to the HB 1065 program, HMA shall provide standard claim processing services to those qualifying claims. In addition, HMA shall adjust processing to apply pricing as required by 1065 and No Surprises Act regulations and to assist the Plan with good-faith negotiation and arbitration case processing. HMA will apply the outcome of any arbitrator's decision on the Plan's behalf. The Plan retains all funding obligations for 1065 and No Surprises Act claims including all ancillary fees and expenses, including but limited to any negotiation support fees charged by HMA and/or its vendor partner. HMA makes no representations implied or otherwise around the Plan's Stop Loss Carrier's independent decision to cover the claim amounts included in an award issued by an arbitrator. The Plan should take steps to ensure that their Stop Loss Partner will cover any arbitration award issued in favor of a provider.

(g) **Stop Loss administration support.**

Provide Stop Loss administration support to the Plan Sponsor. HMA may accept pre-funding checks from Plan Sponsor's Stop Loss carrier on behalf of the Plan Sponsor, however such acceptance shall not deem HMA a Plan Fiduciary. Plan Sponsor/Administrator retains all fiduciary responsibility associated with the Plan. HMA shall submit reimbursement requests to Plan Sponsor's stop loss carrier on behalf of Plan Sponsor, however, submission for reimbursement does not guarantee payment under the stop loss policy, and HMA bears no responsibility for the actions of any stop loss carrier. HMA's support will include, to the extent requested by the Plan Sponsor, facilitating claim submission for prescription drug claims to the Plan's stop loss carrier. Plan Sponsor acknowledges and agrees that timing of prescription claims including but not limited to refills and grace periods, invoicing of claims, obtainment of any prior authorizations, benefit alignment with

SPD language and adherence with any substantiation requirements as administered by the PBM that might be required in order for such prescription claims to be eligible for coverage under the applicable stop loss policy are all factors outside of the control of HMA. Plan Sponsor acknowledges that HMA shall not be liable for any prescription related coverage determination made by the Stop Loss Carrier. Furthermore, the Plan Sponsor is responsible for providing approved Summary Plan Documents to the Stop Loss Carrier and acknowledges that delays in timely approval and submission of Summary Plan Description(s) may result in claim reimbursements being held or denied. Plan Sponsor acknowledges that out of Plan exceptions made by the Plan Administrator may not be covered by stop loss without the express advance written consent of the stop loss carrier. All out of Plan exceptions are made at the Plan's sole risk and liability. Plan Sponsor acknowledges and agrees that in exchange for the performance of Stop loss support provided by HMA, compensation in the form of an administrative fee will be paid to HMA by Preferred Stop Loss Carriers. If the Stop Loss Carrier selected by the Plan Sponsor is non-preferred, HMA at is sole election may agree to work with the Stop Loss Carrier but Plan Sponsor shall be charged a Stop Loss Interface fee as outlined in the Schedule of Fees accepted by Plan Sponsor. HMA reserves the right to decline to work with any Stop Loss Carrier, MGU or other Intermediary in its sole discretion.

(h) **Plan Sponsor Vendor Payment Administration Support.** One of the ministerial functions offered by HMA on behalf of the Plan Sponsor may be the payment of other vendors who have been selected by the Plan Sponsor and who are providing contracted services to the Plan Sponsor's benefits plan (aka consolidated billing). Timely payment of these vendors is solely contingent upon the Plan Sponsor providing timely funding as stipulated in Section 5(a) of this Agreement. HMA does not insure nor underwrite any liability of the Plan Sponsor or the Plan and shall have no financial risk or liability with respect to the provision of, or payment for, any benefits under the Plan, including but not limited to payments to outside vendors on behalf of the Plan Sponsor.

(i) **HMA Vendor Partners.** The work to be performed by HMA under this Agreement may, at its discretion, be performed directly by it or wholly or in part through a subsidiary or affiliate of HMA or under an agreement with an organization, agent, advisor, or other person of its choosing. HMA may delegate certain portions of its work under this Agreement to any other entity. As the ultimate beneficiary of any such agreement, the Plan Sponsor by its execution of this Agreement acknowledges that it will be ultimately responsible for and bound to the payment terms of HMA's contract with the vendor for any costs associated with such services which cannot be incorporated into HMA's fees or which otherwise fall outside the scope of this Agreement. HMA is willing to facilitate certain Plan functions on behalf of Plan Sponsor with selected vendor partners of Plan Sponsor under the following conditions:

(i) HMA reserves the right to charge an additional fee to account for anticipated costs associated with providing services in conjunction with any specific stop loss carrier. Any such fee shall be reflected on Claim Administrative Fee Schedule and/or Client Intent, attached hereto, and will be communicated to Plan Sponsor in advance.

(ii) HMA reserves the right to charge an additional fee for any custom reporting required by a vendor partner that is beyond HMA's standard report package. Any such fee shall be reflected on Claim Administrative

Fee Schedule and/or Client Intent, attached hereto, and will be communicated to Plan Sponsor in advance.

(iii) HMA shall not be liable for claims processed in error based on information provided by Plan Sponsor or Plan Sponsor's third party vendor, including but not limited to inaccurate, incomplete or missing eligibility information or Plan design changes (ie. broker, stop loss, eligibility vendor, intermediary etc.) on behalf of the Plan Sponsor.

(j) **Fidelity Bond.** HMA shall maintain and pay the cost of a fidelity bond in the amount of not less than One Hundred Thousand Dollars ($100,000.00) and an errors and omissions insurance policy in the amount of not less than One Million Dollars ($1,000,000.00).

(k) **Record Keeping.** HMA shall maintain all records relating to the investigation, processing, and payment of all claims for benefits for a period consistent with its then current record retention policies and procedures or as required by law. Upon termination of this Agreement, these records may be transferred to the Plan Sponsor or other person or entity, at the Plan Sponsor's request.

The Plan Sponsor, the Plan Administrator or their agents or representatives may examine any records maintained by HMA regarding claims for benefit payments, benefits paid and the issuing of checks for payment of benefits under the Plan.

4. **Fees to HMA.**

(a) **Fees for Claims Processing Services.** As compensation for the administration and claims processing services, Plan Sponsor shall pay to HMA the fees set forth on Claim Administrative Fee Schedule and/or Client Intent, which is attached hereto and made a part hereof. Fees shall be based on the number of Participants enrolled under the Plan on the first day of the month in which services are being billed, and shall be due and payable within 10 business days of receipt of monthly invoice. Fees for any newly enrolled Participants entering on or after the first day of the month shall be charged retroactive to the date of enrollment and shall be payable on the first day of the month following the date of enrollment. Any adjustments in fees for retroactive changes in enrollment will be made on the first billing cycle immediately following the submission of the change in writing to HMA.

(b) **Fees from Outside Vendors.** HMA may be entitled to a portion of the fees charged by outside vendors, as set forth on Claim Administrative Fee Schedule and/or Client Intent if applicable.

(c) **Use of External Vendors.** Plan Sponsor's use of outside vendors and solutions is subject to review and approval of HMA, which will not be unreasonably withheld, provided that the vendor does not violate any Network restrictions and any operational and data integration expectations required by HMA can be accommodated. Any carve-outs from HMA's services may require execution of hold harmless and/or Data Confidentiality Agreements. HMA reserves the right to access an integration fee which shall be accessed to Plan Sponsor along with any ongoing file support fees that the Vendor may charge to send data to HMA on behalf of Plan. Plan Sponsor acknowledges and agrees that they are solely responsible for ensuring compliance with all regulatory requirements and actions of their selected vendors, and understands that HMA's support of transparency or other regulatory mandates shall not extend to the products or services involving

any vendors and/or products/services that are not procured through HMA's contracts and partnerships.

(d) **Fees for Negotiated Savings.** In the event that HMA is able to negotiate a reduced fee charged by a provider, HMA shall be entitled to retain a percentage of the negotiated savings as stated in the Claim Administrative Fee Schedule and/or Client Intent. In the event that additional negotiation services are needed, the Plan Sponsor and HMA shall mutually agree upon a fee schedule for such services. In the event that HMA is able to negotiate additional savings with a preferred (in-network) provider, fees for HMA's negotiation services will only apply to the additional savings retained below the applicable network rate.

(e) **Shared Savings Programs.** HMA offers a variety of Care Management and Condition Management solutions designed to steer utilization and care to optimal site of care and/or provider. HMA's fees for these programs may include case rates and/or percentage of savings as shown within the current Client Intent and/or Claim Administrative Fee Schedule. HMA shall notify Plan Sponsor of new programs and solutions and advise of fees specific to each offering and provide the opportunity to include these programs within their scope of services with HMA. The Parties acknowledges that HMA and its affiliates have no obligation to pay rebates in connection with Covered Drugs dispensed by Providers and administered to Participants as part of a Covered Service.

(f) **Fees for Repricing of Out of Network Claims.** HMA shall be entitled to retain 30% (thirty percent) of the gross savings obtained on all out of network claims that are repriced, reduced by negotiation or reduced due to audit. The remaining 70% (seventy percent) of savings will be passed on to the client in the form of reduced claims costs.

There will be no cost to the Plan Sponsor for this service for claims that experience no repricing or negotiated savings.

(g) **Reprocessing Fee.** In the event a retroactive amendment or the Plan Sponsor's failure to fund claims in a timely manner results in the need to reprocess claims, the Plan Sponsor agrees to pay HMA's reasonable expenses in performing that service.

(h) **Appeals and other PPACA Related Fees.** Any fees incurred by HMA on behalf of the Plan for appeal related services, including but not limited to costs incurred by an Independent Review Organization, as well as fees incurred as a result of PPACA mandated services (i.e. language translation assistance services) shall be the sole responsibility of the Plan.

(i) **Bank fees and Charges.** All bank related fees or transaction charges (Non-Sufficient Funds fees, dishonored checks, canceled ACH transfers, etc.) incurred by HMA in connection with the services provided to Plan Sponsor shall be the responsibility of Plan Sponsor.

(j) **Right to Change Fees.** HMA shall have a right to change any fees charged to the Plan Sponsor hereunder

(i) as of the first day of any Renewal Term;

(ii) as of the effective date of any changes in applicable federal and state laws that would expand the scope of the services that HMA has agreed to provide hereunder.

(iii) notwithstanding the fees in effect under this Agreement, should there be a change in any law or regulation that results in increased costs to HMA, HMA shall increase its fees to cover such increased costs.

(iv) as a result of Plan Amendments, HMA shall have the right to change its fees upon written notice to the Plan Sponsor in the event any amendment to the Plan changes the amount or type of processing, services or responsibilities undertaken by HMA, effective as of the effective date of the amendment.

(v) as a result of an enrollment change that necessitates a change in how the Plan's primary networks are setup. Additional network access fees, as applicable, for Primary network access in additional States to accommodate enrollment shifts shall be passed through to the Plan for payment.

If HMA elects to change any fees charged to the Plan Sponsor hereunder, HMA shall give prior written notice of such change to the Plan Sponsor as soon as practicable, but in the case of a change pursuant to item (i) no fewer than 30 days prior to the effective date of the change, and the Plan Sponsor may, if it does not want to retain HMA based on the new fee schedule, terminate this Agreement by sending written notice of termination to HMA.

5. **Funding of Benefit Payments and other Expenses and Obligations.**

(a) **Responsibility for Funding Benefits.** Plan Sponsor shall retain the sole responsibility for payment of all Plan benefits. HMA's role shall at all times be merely to process payment. Funding for benefits by Plan Sponsor shall occur within ten (10) business days of the date written claim notification is sent by HMA, unless a different time period was previously agreed upon in writing. Failure to meet this requirement shall require Plan Sponsor to fund all future obligations under this Agreement by "ACH Pull" method of payment, and may result in suspension of services and/or termination of the Agreement under Article 7(d). HMA reserve the right to modify acceptable payment methods that it will accept at any time upon 30 days advance notice to the Plan Sponsor.

(b) **Responsibility for Plan expenses.** Plan Sponsor has sole responsibility for payment of all expenses incident to the Plan, including, but not limited to, all premium taxes, or any other tax, including any penalties and interest payable with respect thereto, assessed against Plan Sponsor. In no event shall HMA have the responsibility to provide funding for the payment of benefits to Plan Participants, for payment of premiums for excess loss insurance or for expenses of the Plan.

(c) **Designated Account.** The Plan Sponsor shall establish, and at all times maintain in strict compliance with all applicable federal and state laws, specifically including, without limitation, the fiduciary bank account requirements of ERISA, a central disbursement checking account (the "Designated Account"), **and** shall deposit in said Designated Account sufficient funds to pay:

(i) all compensation and fees owing to HMA for services rendered hereunder;

(ii) all benefits owing to Participants in accordance with the terms of the Plan, following receipt of claim notification;

(iii) all premiums and fees owing by the Plan Sponsor to third parties for excess loss insurance, PPO arrangements and utilization review; and

(iv) all other authorized costs and expenses incurred by HMA in performing its duties hereunder.

6. **Plan Sponsor Requirements.**

(a) **Duty to Provide Data to HMA.** Plan Sponsor acknowledges that the effective performance by HMA of the administrative services outlined herein will require that the Plan Sponsor furnish various reports, information, and data to HMA. Plan Sponsor shall provide the following reports and information to HMA, together with such other data as HMA may from time to time request:

(i) Accurate and timely identification and verification of individuals eligible for benefits under the Plan, kinds of benefits to which such individuals are entitled, date of eligibility and such other information as may be necessary for processing of benefit payments;

(ii) Notification to HMA, on a monthly or more frequent basis, of all changes in participation whether by reason of termination, change in classification, new enrollment, or any other reason, inclusive of an effective date of such change;

(iii) Administer its enrollment changes consistent with the terms of coverage it offers under its Summary Plan Description(s). Plan Sponsor must ensure that coverage dates are effective and terminated in accordance with the terms of coverage offered to Plan Participants;

(iv) File Enroll Clients must review and supply updated/correct termination dates (if applicable) in response to Termination By Absence reporting that shall be supplied to Plan Sponsor via the Employer reporting portal on a weekly basis for changes in enrollments due to a member being dropped from the last file submitted to HMA. Plan Sponsor acknowledges and agrees that HMA is authorized to use the receipt date of the file in which the member was dropped as the date to terminate coverage under the Plan via Termination By Absence handling protocol. Plan Sponsor may use a HRIS/enrollment vendor provided that the Plan Sponsor remains responsible for data accuracy, timeliness of the information passed to HMA and shall ensure file specifications conform to HMA's file layout requirements which may be updated from time to time with notice to Plan Sponsor and its vendor. HMA shall rely upon the information supplied to it, and shall not be liable for errors resulting from data quality issues received from the file(s) received on Plan Sponsor's behalf;

(v) Plan Sponsor shall ensure that its COBRA administrator is provided the accurate termination date and reason for termination for which to base COBRA offers from;

(vi) The number of Participants covered under the Plan, collectively and separately classified by benefit coverage eligibility, enrollment, geographic area, age, sex, earning level, dependent coverage classifications, and in such other manner, as HMA shall require from time to time.

(vii) Ensure that its systems as well as any vendors utilized by the Plan Sponsor to track, update, maintain and transfer eligibility information to RGA is able to support privacy restrictions including but not limited to Confidential Communications as may be requested by Plan Participants.

(viii) The Social Security numbers for all Participants covered under the Plan.

(ix) All Plan design modifications and benefit changes shall be communicated to HMA at least ninety (90) days prior to the intended effective date, including review and approval of the SPD, Plan Summaries and Amendments. In accordance with the regulations under the Patient Protection and Affordable Care Act (PPACA), Plan Sponsor acknowledges the obligation to notify all plan participants of any plan changes no less than sixty (60) days in advance of the effective date of the modification or change. Retroactive plan design changes may be prohibited under PPACA.

(b) **Duty to Provide Materials.** Plan Sponsor shall provide directly to HMA through HMA to applicable third parties, all materials, documents (including summaries for employees), reports, and notice forms, as may be necessary or convenient for the operation of the Plan, or to satisfy the requirements of governing law, as may be determined or prepared from time to time by HMA. Where distribution to employees is required, such materials shall be furnished in sufficient quantity and shall be appropriately distributed by the Plan Administrator.

(c) **Fidelity Bond.** The Plan Sponsor shall provide a fidelity bond for fiduciaries and employees as required by ERISA for the benefit of the plan.

(d) **Network Compliance.** The Plan Sponsor's ability to access the Provider Network(s) that it has access to through the access fees paid to HMA under this Agreement is subject to the Plan's ongoing adherence to Network requirements as may be communicated either by HMA or the Network(s) directly from time to time. Plan understands that failure to comply with requirements may result in the loss of network discounts and/or the ability to use the PPO Network. Examples, of provider network requirements that the Plan will comply with include but are not limited to timely payment and reimbursement consistent with the terms of a Provider's contract with the Network, Plan design requirements, such as maintaining a 10% benefit differential between Preferred/In-Network, Participating, and/or Out-of-Network benefit tiers.

7. **Term and Termination.**

(a) **Initial Term.** The initial term of this Agreement shall be for a period of one year, commencing as of the Effective Date of this Agreement and terminating, if not renewed, one year thereafter (the "Initial Term"), unless sooner terminated in accordance with the provisions of this Paragraph 7.

(a) **Renewal.** Renewal of this Agreement shall be accomplished by attaching to this Agreement a revised Client Intent form or other such document that may be presented by HMA to Plan Sponsor that confirms Plan Sponsor's intent to renew its services with HMA, which identifies the services to be performed and the associated fees to be paid, along with any other associated disclosure documents that may be presented as a Renewal offer by HMA (the "Renewal") that is which shall include an updated Schedule of Commissions and Administrative Fees, signed by the parties to this Agreement and setting forth the term of such renewal (the "Renewal Term"). In the event a revised Renewal Client Intent From is not signed by the parties, but the parties continue to perform under this Agreement, then it shall be deemed to be renewed for successive one (1) year periods until terminated. HMA at its sole discretion may continue to provide services for a period of time under the last executed Renewal Client Intent or initial sale documents but shall be entitled to payment of all fees as outlined in the Renewal Client Intent upon execution without any proration or forgiveness due delay in execution.

(b) **Termination by Either Party.** This Agreement may be terminated by either Plan Sponsor or by HMA by written notice of intention to terminate given to the other party, to be effective as of a certain date set forth in the written notice, which shall not be less than ninety (90) days from the date of such notice.

Upon termination by either party, within thirty days after the date of termination, HMA shall prepare and deliver a complete and final accounting and report as of the date of termination of the financial status of the Plan to the Plan Sponsor, together with all books and records in its possession and control pertaining to the administration of the Plan. All claim files, enrollment materials and other papers necessary for claim payments under the Plan shall be available to the Plan Sponsor upon the date of termination of this Agreement. If requested, HMA will process run- out claims (claims incurred prior to the date of termination). The charge for run-out claim processing will equal 3 months of current administrative fees and the duration will be 12 months. HMA will provide a final accounting to Plan Sponsor on its order.

In the event that HMA offers and Plan Sponsor accepts a multi-year fixed rate guarantee for a Renewal Term, as shown within the Schedule of Commissions and Administrative Fees included within the Client Intent form, Plan Sponsor will pay an Early Termination Fee if Plan Sponsor terminates this Agreement prior to the end of the applicable Renewal Term for which the rate guarantee applies, except that the Early Termination Fee will not be due if Plan Sponsor's termination of the Agreement is for HMA's breach of the Agreement or for HMA's negligence or willful misconduct. The Early Termination Fee will be payable in addition to any run-out service fees or other costs owed by Plan Sponsor to HMA under this Agreement. The Early Termination Fee will be an amount equal to 25% of the "Claim Administrative Fees" shown in the applicable Schedule of Commissions and Administrative Fees that, absent termination of the Agreement, would have been otherwise due to HMA during the remainder of the applicable Renewal Term. The Early Termination Fee shall be determined based on enrollment data calculated at an average enrollment head count for the 3 months prior to the termination date of the Agreement.

(c) **Events Triggering Immediate Termination.** In the event of willful misconduct or gross negligence by a party to this Agreement, the other party may terminate this Agreement immediately upon written notice. In addition, HMA shall have the

right, in its sole and absolute discretion, to terminate this Agreement immediately if:

(i) After written notice to cure, the Plan Sponsor fails to cure a material breach of any provision of this Agreement within ten days of the date of the notice to cure. A material breach includes, but is not limited to, failure to pay fees or charges owing HMA, failure to fund benefit payments in a timely manner, or failure to fund the Designated Account as specified in Section 5 above. The notice to cure shall describe the nature of the breach with reasonable particularity; or

(ii) The Plan Sponsor becomes insolvent, is adjudicated bankrupt, voluntarily files or permits the filing of a petition in bankruptcy, makes an assignment for the benefit of creditors, or seeks any similar relief under any bankruptcy laws or related statutes.

(d) **Termination of Plan.** If the Plan is terminated, for whatever reason, this Agreement shall automatically terminate as of the effective date of such termination except as set forth in 7(c) if run-out processing is elected.

8. **Effect of Termination**. Upon termination of this Agreement, all obligations of HMA hereunder, specifically including but not limited to all obligations to process claims for benefits and disburse benefit payments, shall terminate, and all rights of Plan Sponsor hereunder shall cease, and HMA shall not be liable to Plan Sponsor for any damage whatsoever sustained or arising out of, or alleged to have arisen out of, such termination. Notwithstanding anything express or implied herein to the contrary, the termination of this Agreement shall not affect the right of HMA to receive and recover all fees then owing by the Plan Sponsor to HMA hereunder or the rights of the parties under Sections 9 and 10 of this Agreement.

9. **Indemnification and Lawsuits Against the Parties**

(a) **Claims Disputes.** In the event a dispute arises with a Participant or other third party over GHP benefits or any action taken by HMA related to the payment of GHP benefits in the performance of HMA's duties under the Agreement (referred to in this Agreement as a "Claim Dispute"), the Parties agree to the following:

(i) When a Party reasonably determines that a Claim Dispute may arise, the Party will promptly notify the other Parties in writing as to the issues involved in the Claim Dispute; and

(ii) If HMA is a party to any legal action related to or arising out of a Claim Dispute, HMA will defend itself against any such legal action (including, but not limited to, litigation, arbitration, and/or mediation) brought by or on behalf of any Participant or other third party, and HMA will have full discretionary authority in all matters related to the conduct, defense, or settlement of any such action, including, but not limited to, the selection of counsel and pursuit of any counter- or cross-claim. As provided in Section 9(b), GHP and Plan Sponsor, jointly and severally, shall are responsible for pay HMA's legal fees and costs, including attorney fees, incurred by HMA in defending any legal action related to or arising out of a Claim Dispute, in addition to GHP and Plan Sponsor's indemnity obligations set forth in Section 9(b). including but not limited to, the payment of counsel and filing, court, arbitrator, mediator, and other

similar fees and expenses, and Plan Sponsor and GHP, jointly and severally, agree to reimburse and indemnify HMA for such costs, provided that Upon request, HMA shall provide supporting documentation, to GHP or Plan Sponsor, of its litigation defense costs.

(b) **Indemnification.** The Parties agree to the following indemnification provisions:

(i) Plan Sponsor and GHP, jointly and severally, will indemnify, defend and hold harmless HMA, HMA Affiliates, and their respective directors, officers, employees (acting in the course of their employment, but not as claimant) and agents, for that portion of any liability, settlement and related expense (including the cost of legal defense through and including any appeals) resulting solely and directly from Plan Sponsor's or GHP's breach of this Agreement, negligence, gross negligence, willful misconduct, criminal conduct, fraud or breach of a fiduciary responsibility related to or arising out of this Agreement.

(ii) HMA will indemnify, defend and hold harmless Plan Sponsor and GHP, their affiliates and their respective directors, officers, employees (acting in the course of their employment, but not as claimant) and agents, for that portion of any liability, settlement and related expense (including the cost of legal defense through and including any appeals) resulting solely and directly from HMA's breach of this Agreement, negligence, gross negligence, willful misconduct, criminal conduct, fraud or breach of a fiduciary responsibility related to or arising out of this Agreement.

(iii) Plan Sponsor and GHP, jointly and severally, will remain obligated for: (1) indemnifying HMA for any Claim Dispute under Section 9(a) of this Agreement, including the litigation defense fees and costs set forth in Section 9(a)(ii); (2) indemnifying HMA from any claim or loss which results from Plan Sponsor's incorrect certification of Participant eligibility; (3) the payment of all GHP benefits; (4) any fines or penalties imposed by federal, state, or other regulator in connection with HMA filing forms, analysis or other required documents to such regulators on GHP's or Plan Sponsor's behalf; (5) any tax consequences, fees, or penalties resulting from the GHP plan design; and (6) the payment of all benefits, costs or damages when the acts giving rise to the liability were performed by Plan Sponsor or GHP, or by HMA upon Plan Sponsor's or GHP's direction. HMA will not be considered negligent if HMA's claims processing services are performed in accord with the standards of Section 3(c). HMA will not be considered negligent for failing to meet any standards listed in ASC Performance Guarantees Addendum, the consequences of any such failure of which are addressed exclusively in the Performance Guarantees Addendum.

(c) **Exclusion from Indemnification.** Regardless of fault, HMA shall not be responsible for funding the Plan's benefit payments, or for Plan Sponsor's lost profits, extrapolations of improper benefit payments, exemplary, special, punitive or consequential damages.

10. **Records Access and Audit Rights.** Subject to the provisions of this Paragraph 12, Plan Sponsor may audit HMA's compliance with its obligations under this Agreement and HMA shall supply Plan Sponsor, with access to information acquired or maintained by HMA in performing services under this Agreement. HMA shall be required to supply only such information which is in its possession and which is reasonably necessary for the Plan Sponsor to conduct such audit, provided that such disclosure is not prohibited by law or

by any third-party contracts to which HMA is a signatory. Plan Sponsor hereby represents and warrants that, to the extent any disclosed information contains Protected Health Information (as defined by the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA")) about a Participant, Plan Sponsor has the legal authority to have access to such information. Plan Sponsor shall give HMA 60 days' prior written notice of its intent to perform such an audit and its need for such information and shall represent to HMA that the information, which will be disclosed therein, is reasonably necessary for the administration of the Plan. All audits and information disclosure shall occur at a reasonable time and place and at the Plan Sponsor's sole cost and expense. Prior to commencement of any audit, all Auditors will be required to sign an HMA Auditor Agreement.

11. **Overpayment or Improper Payment of Plan Benefits.** If any payment is made hereunder to an ineligible person, or if it is determined that an overpayment or improper payment has been made to any party, HMA shall make reasonable efforts to recover the overpayment or improper payment, but shall not be required to initiate court proceedings for any such recovery. If HMA is unsuccessful, HMA shall notify Plan Sponsor in order that Plan Sponsor may take such action as may be available to it.

12. **Additional Payments to Claimants.** Plan Sponsor may, by written notice to HMA signed by an executive officer of the Plan Sponsor, instruct HMA to pay claims, which in HMA's opinion are not payable under the Plan, upon the condition that such instruction expressly releases HMA from any liability in connection therewith. Plan Sponsor hereby acknowledges that such payments will not qualify for credit toward excess or stop loss insurance coverage, and as such, are considered "outside" the Plan, unless otherwise agreed upon in writing by the Plan's stop-loss carrier. Plan Sponsor retains all legal requirements for such payment.

13. **Cooperation in Defense of Claims.** HMA and Plan Sponsor shall advise each other as to matters which come to their respective attentions involving potential legal actions or regulatory enforcement activity which involve the Plan or are related to the activities of either party with respect to the Plan or this Agreement and shall promptly advise each other of legal actions or administrative proceedings which have actually commenced.

14. **Notice of Third Party Administrator's Capacity.** HMA shall notify all Participants in writing of its identity and its relationship to the Plan and the Plan Sponsor in such form and manner as approved by the Plan Sponsor.

15. **Plan's Compliance with Laws.** Plan Sponsor represents and warrants that the Plan presently complies with all applicable federal, state and local laws and regulations, specifically including, but not limited to, ERISA, Mental Health Parity and Addiction Equity Act ("MHPAEA"), Patient Protection and Affordable Care Act ("PPACA") the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), HIPAA and HITECH, the Consolidated Appropriations Act of 2021, and covenants and agrees that it will, at its sole cost and expense, take all action necessary to cause the Plan's continued compliance with all applicable federal, state and local laws and regulations during the term of this Agreement. Plan Sponsor is solely responsible for obtaining any actuarial analysis, non-discrimination testing, or actuarial determinations required by the Plan. HMA's services to assist Plan Sponsor's with their compliance obligations are limited to directly supporting the services provided by HMA to the Plan Sponsor, and do not extend to any services that the Plan Sponsor is receiving through external parties (i.e. PBM, benefit specific carve-outs, advocacy services, etc.), unless otherwise agreed to in writing by a duly authorized officer of HMA as an addendum to this Agreement, for which the Plan Sponsor remains solely liable.

18. **Miscellaneous.**

(a) **Entire Agreement.** This document is the entire, final and complete Agreement and understanding of the parties regarding the subject matter hereof and supersedes and replaces all written and oral agreements and understandings heretofore made or existing by and between the parties or their representatives with respect thereto.

(b) **Severability.** In the event any one or more of the terms, conditions or provisions contained in the Agreement or any application thereof shall be declared invalid, illegal or unenforceable in any respect by any court of competent jurisdiction, the validity, legality or enforceability of the remaining terms, conditions or provisions of this Agreement and any other application thereof shall not in any way be affected or impaired thereby, and this Agreement shall be construed as if such invalid, illegal or unenforceable provisions were not contained herein.

(c) **Restriction on Assignment.** Except as provided in section 3(c), neither party shall assign or transfer any of its rights or delegate any of its duties or obligations hereunder, directly or indirectly, without the prior written consent of the other party; provided, however, that either party may, upon 60 days written notice to the other party, assign this Agreement in its entirety to any person or entity, other than a direct competitor of the other party, which acquires the business of the assigning party or with which the party merges or is consolidated or affiliated, provided that the permitted assignee agrees in writing to be bound by the terms of this Agreement. Any attempted assignment, transfer or delegation in violation of this Paragraph 18(c) shall be null and void.

(d) **Notices.** All notices, requests, demands and other communications required or permitted to be given or made under the Agreement shall be in writing and shall be deemed delivered, if by personal delivery, on the date of personal delivery, if transmitted and confirmed by electronic mail or facsimile transmission, on the date of the transmission, if by U.S. certified or registered mail, postage prepaid, on the third business day following the date of deposit in the United States mail, or, if by nationally recognized overnight courier services, on the first business day following the date of delivery to such service, and shall be sent to Plan Sponsor or HMA, as the case may be, at the address shown on the first page of this Agreement, or to such other address, person or entity as either party shall designate by notice to the other in accordance herewith.

(e) **Binding Effect.** This Agreement shall be binding upon, inure to the benefit of, and be enforceable by, the parties hereto and their respective successors and permitted assigns.

(f) **No Third Party Beneficiaries.** Nothing in this Agreement, express or implied, is intended to confer on any person, other than the parties hereto, any right or remedy of any nature whatsoever, and nothing in this Agreement shall create, or be deemed to create, any rights, obligations or legal relationship between HMA and any Participant in the Plan.

(g) **Fines and Penalties.** In the event that Plan Sponsor fails to provide any of the data specified in Article 6 of this Agreement, **Plan Sponsor Requirements**, and said failure results in a fine or penalty, the full amount of the fine or penalty shall be passed through to Plan Sponsor for payment.

(h) **Force Majeure.** The parties will make their best effort to deliver services at the time specified herein. However, neither party shall have an obligation or liability whatsoever arising out of, or in connection with, any delay or failure to perform any of its duties or obligations under this Agreement, or any loss or damage incurred as a result thereof, if such delay or failure is caused, in whole or in part, either directly or indirectly, by act of God, fire, war, riot, civil insurrection, accident, embargo, governmental priority, failure of third parties to perform, criminal act (unless committed by someone in the employ of the offending party), strikes or other labor dispute, decree or order of any court or government, or any other occurrence, act, cause or thing beyond the control of the parties, whether related or unrelated or similar or dissimilar to any of the foregoing, which prevents, hinders or makes fulfillment of this Agreement impractical, any of which shall, without liability, excuse either party from performance of this Agreement.

(i) **Authorization.** Plan Sponsor represents and warrants to HMA that:

(i) it is a corporation duly organized, validly existing and in good standing under the laws of the state in which it is organized;

(ii) the execution, delivery and performance of this Agreement has been duly authorized by all requisite action of Plan Sponsor's Board of Directors; and

(iii) this Agreement constitutes a valid and binding contract of Plan Sponsor in accordance with its terms.

(j) **Attorneys' Fees.** In the event of a dispute under this Agreement, the prevailing party shall be entitled to recover reasonable costs and attorneys' fees incurred in connection with such dispute.

(k) **Waiver.** No waiver of any provision of this Agreement shall be deemed, or shall constitute, a waiver of any other provision, whether or not similar, nor shall any specific waiver constitute a prospective waiver or release the applicable party from any duties for continued performance. No waiver shall be binding unless executed in writing by the party making the waiver.

(l) **Amendment.** No supplement, modification or amendment of this Agreement shall be binding, unless the same is in writing and signed by duly authorized representatives of both parties.

(m) **Arbitration.** Plan Sponsor and HMA shall submit any and all disputes relating to or arising out of this Agreement to final and binding arbitration. Arbitration will be before a single arbitrator in Seattle, Washington, who is affiliated with a recognized panel of arbitrators such as the American Arbitration Association, Judicial Dispute Resolution or Judicial Arbitration & Mediation Services. Either party may initiate an arbitration by giving written notice to the other of a demand for arbitration. If the parties fail to agree upon the arbitrator to be used within ten (10) days of a party's arbitration demand, the arbitrator may be appointed by the Superior Court of the State of Washington for King County pursuant to Chapter 7.04 RCW at the instance of either party, and both parties shall submit to the jurisdiction of such court for the purpose of any such appointment. The arbitrator shall be an individual who is or has been actively engaged in the practice of law or who has served as state or federal court judge. Except as otherwise specified by this Agreement or other written agreement of the parties, the arbitration shall be

conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"), using the Expedited Procedures applicable to such rules (irrespective of the size or nature of any party's claim), but need not be administered by the AAA. The parties agree that any suit brought to compel arbitration or enforce an arbitration award shall be brought in the applicable court in Seattle, WA and the parties consent to jurisdiction thereof for that purpose.

(n) **Governing Law.** This Agreement shall be deemed to have been executed and entered into in Bellevue, Washington and shall be governed, construed, performed and enforced in accordance with the laws of the State of Washington, without regard to its conflict of law principles.

(o) **Headings.** The headings used in this Agreement are solely for convenience of reference, are not part of this Agreement, and are not to be considered in construing or interpreting this Agreement.

(p) **Counterparts.** This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, and all of which together shall constitute one and the same instruments.

(q) **HIPAA.** The Plan Sponsor shall appropriately safeguard and limit the use and disclosure of enrollees' Protected Health Information, which the Plan Sponsor may receive from HMA, in accordance with the requirements of 45 Code of Federal Regulations §164.504(f)(2).The Plan Sponsor agrees that the Plan will be in compliance with all requirements involving the use or disclosure of protected health information as provided for in 45 C.F.R. Part 164. The duties and responsibilities of HMA in connection with the requirements imposed by HIPAA and regulations promulgated thereunder will be set forth in the Business Associate Agreement entered into between the Parties to this Agreement.

(r) **Confidential Information.** Neither party shall disclose confidential information to any other entity without the prior written consent of the party that holds the right, title and interest in the information. Confidential information means all confidential and proprietary information that includes information not generally known to the public, is maintained by the party that holds the right, title, and interest in the information as confidential, and may contain information which has commercial value or other business utility. All HMA confidential information must be transmitted by or attached to an email to the City containing the words, "This email contains Confidential Information subject to a Confidentiality Agreement." Any HMA confidential information not so transmitted or attached is not confidential information for the purposes of this section.

Regardless of the foregoing, this contract and all invoices, pricing, and documents stating what the City pays the HMA are never confidential, regardless of whether or not it is marked confidential by HMA. If confidential information is inputted into a City system, such as Cayenta, POs, or the City's Contract Management System, the information loses its confidential designation and is no longer confidential information for the purposes of this section.

Nothing in this section shall prohibit the disclosure of any confidential information required by law, but in the event of any such disclosure, the disclosing party shall within a reasonable time notify the other party in writing, describing the circumstances of and extent of the disclosure.

(s) **Proprietary Information, Confidentiality.** Neither party shall disclose proprietary information to any other entity without the prior written consent of the party that holds the right, title and interest in the information. Nothing in this section shall prohibit the disclosure of any information required by law, but in the event of any such disclosure, the disclosing party shall immediately notify the other party in writing, describing the circumstances of and extent of the disclosure. This provision shall survive termination of this Agreement. To the extent that the Plan Sponsor requests access to and is granted access to information that is Proprietary and Confidential to HMA and/or one of its Vendors, such as by way of example Provider Network Agreements or negotiated rates, the Plan Sponsor agrees to maintain such data or information in strict confidence and shall not use or disclose any Confidential Information with anyone who is not bound by a non-disclosure Agreement that is as protective as the Plan Sponsor would use for its own proprietary and confidential information. Each party agrees that unauthorized disclosure of Proprietary and Confidential Information of the other party may cause such other party irreparable harm and that any breach or threatened breach of this provision by either party will entitle the other party to seek injunctive relief, without the need of posting a bond, prohibiting the break, in addition to any other legal or equitable remedies available to it, which remedies will not be deemed exclusive, but will be cumulative.

(t) **Systems Property of HMA.** To perform its duties hereunder, HMA shall use certain computer systems (including, but not limited to, software) and other systems and property. Such systems and property are proprietary and the exclusive and confidential property of HMA. The hiring of HMA to provide services under this Agreement gives neither Plan Sponsor nor the Plan any right to such systems, or to the inspection thereof. HMA reserves the right to change its systems and other technology at any time and from time to time, without notice or obligation to Plan Sponsor or the Plan. Confidential system property of HMA is not accessible to the Plan Sponsor or Plan Administrator except as provided in Section 12 of this Agreement.

(u) **Marketing/Advertising Authorization.** By executing this Agreement, Plan Sponsor consents to HMA's use of the Plan Sponsor's company name, logos, trademarks, and identifying information in marketing materials during the period which Plan Sponsor remains an active HMA client.

(v) **Conflict of Interest.** HMA declares that no conflict of interest with the City exists, nor do they have an affiliation with or involvement in any organization or entity which may pose a financial or non-financial conflict of interest with the City.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives on the respective dates set forth below, effective as of the day and year first above written.

Plan Sponsor:		**HMA:**	
City of Everett		Healthcare Management Administrators, Inc.	
By:		**By:**	Aadam Hussain
Name:	Cassie Franklin	**Name:**	Aadam Hussain
Title:	Mayor	**Title:**	President
Date:	02/20/2025	**Date:**	02/20/2025

APPROVED AS TO FORM
OFFICE OF THE CITY ATTORNEY
EVERETT

EVERETT
Attest:
Office of the City Clerk

HMA

Proving What's Possible in Healthcare®

HMA CLIENT INTENT & EXHIBIT A SCHEDULE OF FEES

City of Everett 020188

01/01/2025 through 12/31/2025 Renewal

Account Information

Group Name:	**City of Everett**		**Group: # 020188**
Group Size:	Employees 1,071	**Network:** HMA	**Contract Period:** Year 1
Enrollment Type:	File		
Broker (firm):	Alliant Insurance Services, Inc. – Seattle		
Contact Info	**Name**	**Phone**	**Email**
Broker Contact:	Gene Santoy	(206) 204-9186	Gene.santoy@alliant.com
Account Manager:	Audrey Olson	(425) 289-5253	Audrey.Olson@accesstpa.com

Client Insight Recommendations

HMA continuously strives for innovation and excellence in serving you. Please see your Client Insights PDF for more information on our recommendations for your Plan. Check the corresponding boxes below for the recommendation you want to implement.

Remove/ Exclude	Add/ Accept	Benefit Recommendations
		Medical Travel Benefits – Steerage
☑	☐	Add a Medical Travel Benefit for Steerage to a lower cost provider when criteria are met. Benefit is covered at 100% deductible waived, in and out of network. If the plan is an HDHP, the deductible will apply. • Lodging limited to $200 per night • Meals limited to $100 per person/per day • Mileage will be reimbursed per IRS limits
		If the Plan would like to adjust the reimbursement amount for lodging and meals, please indicate below. Lodging dollar limit **$**_____ Meal dollar limit **$**_____
☑	☐	Include allowance for an additional parent/caregiver for members under the age of 18 or disabled.

Summary of Communicated Benefit Changes (Medical, Dental, Vision, Rx, Buy-Up Products)

Vendors

To support members better, we include information in our systems for HMA's Customer Care Team to leverage and educate members about available services.

Vendor type	Current vendor name	Change?	New vendor name & information
PBM	CVS Caremark/EHPCO	☐	
Member Advocacy or Concierge Service	Alliant Benefit Advocates	☐	
CDHP*	Peak One (HRA)	☐	
COBRA	Peak One	☐	
Dental	Delta Dental of WA Willamette Dental WPAS	☐	
Kidney Dialysis		☐	
Maternity		☐	
Telehealth	98Point6	☑	Terminating 12/31/24
Vision		☐	
Disease Management		☐	

Vendor type	Current vendor name	Change?	New vendor name & information
Data Analytics	Cedargate	☐	
Other Vendor	Vera Whole Health	☐	

* Consumer-driven Health Plan (CDHP), e.g. HRA, FSA, HSA, LPFSA, DCRA.
* Please note that if you choose to work with a non-preferred vendor, we may not be able to integrate eligibility, claims reporting, or accumulators and additional fees may apply.

Fees

Claim Administrative Fees

Rates for the contracted time period apply to services administered by HMA. Fees for outside vendors are subject to change at any time. HMA fees and commissions may remain in effect beyond the above-stated term until changed by mutual written agreement of the parties. **HMA reserves the right to pass through any and all regulatory assessments, fees, or similar financial obligations that are attributable to a client health plan whether known or not during the renewal process or that may become applicable during the term of HMA's services to a client and its health plan. HMA shall use reasonable efforts to identify and communicate to clients about assessments that it will be liable for but shall bear no liability for such obligations.**

Fee	Product	Description
$18.45	**Medical Plan Administration PEPM**	If all documents are signed and returned by **10/31/2024**, the new PEPM with $.20 discount will be **$18.25**.
$5.50	**HMA PPO Network Access PEPM**	HMA Preferred provides access to Regence BlueShield in Western Washington, Asuris NW Health in Eastern Washington, Regence BlueCross BlueShield of Oregon, Regence BlueShield of Idaho, and Regence BlueCross BlueShield of Utah. PHCS provides network access in all other states.
$3.75	**Care Management PEPM**	HMA's Care Management suite of services is an in-house program that encompasses pre-authorization, utilization management, case management, behavioral health, and steerage. HMA's care management team serves members based upon their diagnosis offering full support of the member's healthcare journey, as well as oversight of plan spend. • Utilization Review (Prior Authorization) including Population Health, Specialty Health, Intake • Case Management including Member Support (Clinical), Transition of Care, Continuity of Care, and Discharge Planning staffed by our in-house, highly skilled, certified Case Managers and Register Nurse (RN) Case Managers.
Waived	**HCBB Comply Tool**	HMA's shoppable services tool which is provided to you to satisfy federal transparency requirements. Additional cost-saving, utilization-driving features are available through the Healthcare Bluebook premium buy-up options.
$0.45	**Federal Transparency Technology Enablement PEPM**	Self-funded health plans are subject to seven new to ongoing and new transparency-related federal regulatory requirements. These requirements represent a massive technology lift and investment. We are passing through only a portion of the real costs of delivering these requirements.

30% of savings	Medical bill audit, out-of-network claim re-pricing services, claims negotiation and medication steerage program.
30% of savings	Electronic review of claims for code edits prior to payment.
27% of recovered funds	Subrogation services The plan will receive 73% of recovered funds. Of the remaining, 22% is retained by The Phia Group, and 5% is retained by HMA.* * In the event of litigation to enforce the Plan's right of recovery, The Phia Group fee will increase to 33.3% and HMA shall not retain any compensation.
15%-30% of recovered funds	Data Mining and overpayment recovery 15%-17% recovery fee retained by Cotiviti[i] ○ 15% current claims ○ 17% aged claims On post-payment COB and Code Edit recoveries identified by Cotiviti, additional 13-15% retained by HMA.
9.5% of recovered funds	Credit balance premier health services partner on site with providers across the country.
30% of savings	Fraud, waste, and abuse ○ 17.5% of savings retained by Optum ○ 12.5% administrative allowance retained by HMA

Current Products and Services

What you currently have: These are the products and services you are currently providing to members. Please check the box in the Continue or Remove columns to indicate your selected action for the upcoming plan year.
Products and services offered through partners on our contract may experience price/fee changes or terminate during the Plan Year. Plan Sponsor acknowledges and agrees that the fees quoted below for such services are not guaranteed. In the event of a pricing change during the term, HMA will make every effort to notify you at least 30 days in advance of such changes.

Continue	Remove	Current Fee	Renewal Fee	Product
☒	☐	**$2.50**	**$2.50**	**Dental Plan Administration PEPM**
☒	☐	**$1.50**	**$1.50**	**HMA National Dental Network Access PEPM**
☒	☐	**$0.65**	**$0.65**	**Vision Hardware Administration PEPM**

Additional Products and Services

Additional Buy Up Options: Please review the additional buy-up product options below. Check the box in the Add column if you would like to include these services in the upcoming plan year.

Products and services offered through partners on our contract may experience price/fee changes or terminate during the Plan Year. Plan Sponsor acknowledges and agrees that the fees quoted below for such services are not guaranteed. In the event of a pricing change during the term, HMA will make every effort to notify you at least 30 days in advance of such changes.

Add	Renewal Fee	Product
☐	$3.95	**Flexible Spending Account (FSA) PAPM** Only available with a PPO or non-Qualified Plan.
☐	$3.95	**Dependent Care FSA (DC FSA / DCRA) PAPM**
☐	$3.95	**Health Reimbursement Account (HRA) PAPM**
☐	$2.70	**Health Savings Account (HSA) PAPM**
☐	$1.95	**Limited Purpose FSA (LPFSA) PAPM** Only available with a qualified HDHP.
☐	$1.35	**COBRA Services PEPM**
☐	$2.00	**Consolidated Billing PEPM - Option 1** *Premium Remittance only*
☐	$3.00	**Consolidated Billing PEPM - Option 2** *Premium Remittance AND Eligibility Administration*
☐	$2.10	**PACE Fiduciary PEPM**
☐	$2.00	**Care Navigator PEPM**
☐	$4.00	**Care Navigator Plus PEPM** Clients choose between reducing the member health plan contributions or digital gift cards as an incentive for those members who complete their health questionnaire within the specified timeframe determined by the Plan. **Please select one of the options below:** ☐ **Employer Managed Incentive: We will provide reporting of members qualifying for the incentive via BenefitFocus, employer assumes all liability for the incentive design and execution.** ☐ **$25 digital gift card automatically sent to member-provided email from Tango Platform upon employer funding of Tango account.** ☐ **$50 digital gift card automatically sent to member-provided email from Tango Platform upon employer funding of Tango account.**
☐	$2.25	**Healthcare Bluebook Quality + Go Green Rewards PEPM** Rewards range from $25-$100 when a member selects a fair price provider.
☐		**Healthcare Bluebook Engagement Rewards (Client Funded)** Add to HCBB Quality + Go Green as an enhanced and tiered incentive for members with an expanded selection of over 400 procedures and higher reward amounts ranging from up to $350 for outpatient procedures to a max of $1000. **Requires client to provide email addresses of all eligible employees.**

Add	Renewal Fee	Product
☐		**Healthcare Bluebook Care Connect (Client Funded)** Add to HCBB Quality + Go Green and Engagement Rewards for a concierge service for joints, spine, and women's surgical procedures health including finding the right provider, scheduling appointments, and facilitating medical record transfer. Case rates range from $700 to $5,500 with engagement rewards up to $1,500 for qualifying procedure. **Requires client to provide email addresses of all eligible employees.** **Cannot be combined with Care Navigator Plus.**
☐	**$200 initial consultation** **$550 case rate for Recovery Phase (covers 12 months per injury/issue)**	**Omada for Musculoskeletal** Billed as medical claims. No cost for Prevention program. Member cost share applies. Standard Plan Design is as follows: *covered services shall be covered at 100% DW for PPO Plan(s) and 100% after deductible for QHDHPs plan(s). If Plan sponsor wants to have Omada services covered differently than indicated here, please use the Summary of Communicated Changes box at the top of this document to indicate your alternate plan design intent.*
☐	**$1.50**	**Wellness Hub PEPM**
☐	**$125**	**Incentive Administration per hour** After initial setup of 5 hours included.
☐	**$3.50**	**Disease Management PEPM**
☐	**$350**	**Maternity per case**
☐	**$0.65**	**24 Hour Nurse Line PEPM**
☐	**$1.60**	**MDLIVE Mental Health, Psychiatry, Virtual Dermatology and Medical (Urgent Care) PEPM** **Please detail the group's required cost share for any plans that apply:** ☐ **PPO plan** member copay amount of **$**_____ per virtual visit, **deductible waived** ☐ **PPO plan** member copay amount of **$**_____ per virtual visit **after deductible met** ☐ **HDHP plan** member coinsurance amount of _____%
☐	**$1.35**	**MDLIVE Mental Health, Psychiatry and Medical (Urgent Care) PEPM** **Please detail the group's required cost share for any plans that apply:** ☐ **PPO plan** member copay amount of **$**_____ per virtual visit, **deductible waived** ☐ **PPO plan** member copay amount of **$**_____ per virtual visit **after deductible met** ☐ **HDHP plan** member coinsurance amount of _____%
☐	**$1.30**	**MDLIVE Virtual Dermatology and Medical (Urgent Care) PEPM** **Please detail the group's required cost share for any plans that apply:** ☐ **PPO plan** member copay amount of **$**_____ per virtual visit, **deductible waived** ☐ **PPO plan** member copay amount of **$**_____ per virtual visit **after deductible met** ☐ **HDHP plan** member coinsurance amount of _____%

Add	Renewal Fee	Product
☐	$1.00	MDLIVE Medical (Urgent Care) Only PEPM Please detail the group's required cost share for any plans that apply: ☐ PPO plan member copay amount of $_____ per virtual visit, deductible waived ☐ PPO plan member copay amount of $_____ per virtual visit after deductible met ☐ HDHP plan member coinsurance amount of _____%
☐	$2.60	Virtual Behavioral Health Product Option A PEPM *(6 counseling + 6 coaching per enrolled employee/family unit, per incident, per year)* *(By election Virtual Health Option, A or B, any exclusions within the SPD will be updated to align with Virtual Behavioral Health product offerings)*
☐	$3.75	Virtual Behavioral Health Product Option B PEPM *(12 counseling + 12 coaching per enrolled employee/family unit, per incident, per year)* *(By election Virtual Health Option, A or B, any exclusions within the SPD will be updated to align with Virtual Behavioral Health product offerings)*

***A $2.00 per card ID Card Fee applies when changes are made to the template, for example, deductible and out-of-pocket or Pharmacy Benefit Manager changes. Incidental individual card replacement or reissue available upon member request through our portal at no cost.**
****HMA reserves the right to invoice costs plus 20% of printing and mailing charges for member materials. Printing and mailing member materials and other collateral, including but not limited to SBCs, Member Guides, product flyers, etc.**
*****HRIS vendor change requests within-3 years of initial set-up incur a charge of $5,000.**

Pharmacy Benefit Administration

☑ I have read and accept the attached terms and conditions regarding PBM Fees & Services.

Stop Loss Services

☑ I have read and accept the attached terms and conditions regarding Excess Loss Services.

Renewal Products and Disclosures Acknowledgement

☑ I have read the attached Renewal Product Terms and Disclosures, and I accept the terms and conditions contained within.

This Agreement incorporates by reference the terms and conditions set forth in the Renewal Product Terms & Disclosures document, as if fully set forth herein.

Acceptance

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives on the respective dates set forth below, effective as of the day and year first above written.

By:	City of Everett X Chel Bardwell	**By:**	Healthcare Management Administrators X DocuSigned by: Aadam Hussain 8E17DECAC31547F...
Name:	Chelsi Bardwell	**Name:**	Aadam Hussain
Title:	HR Operations Manager	**Title:**	President & CEO
Date:	09/25/2024	**Date:**	September 26, 2024 | 8:24 AM PDT

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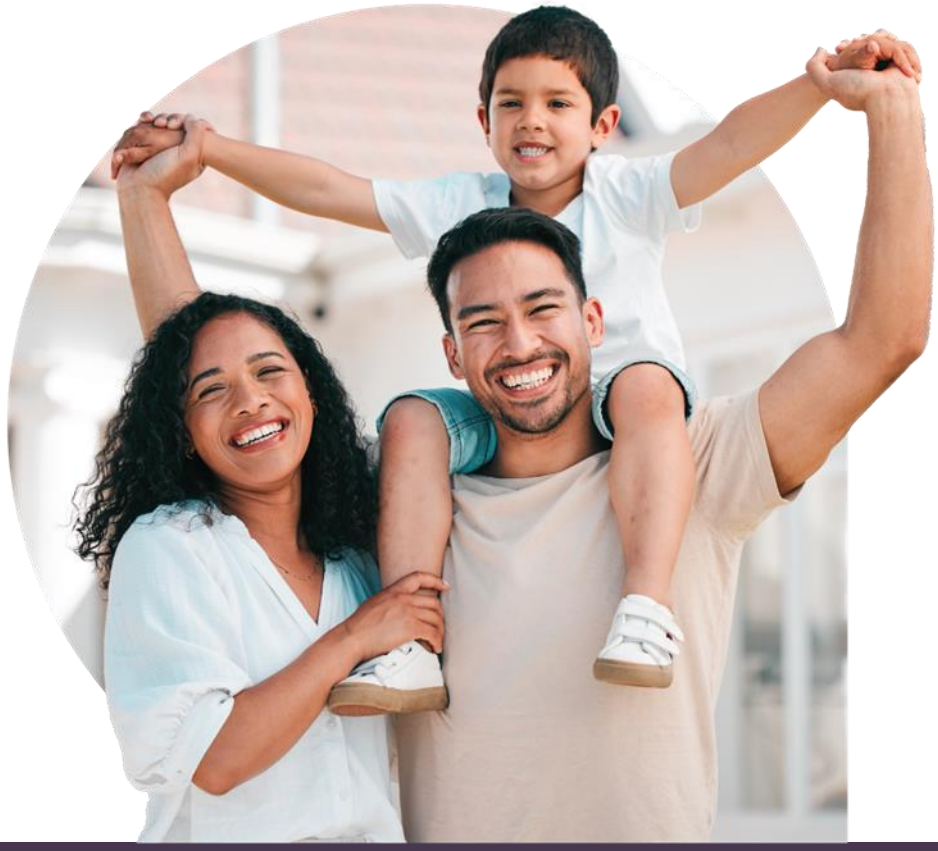

City of Everett

Renewal Product Terms and Disclosures

Effective date: January 1, 2025

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Executive Summary

HMA is a people-forward, values-based health plan administrator. With us, you have access to a best-in-class network and the ability to build a custom plan that meets the needs of your employees and organization—with the flexibility to change alongside you. We are rigorous stewards of your healthcare dollars, offering industry-leading payment integrity programs that protect your funds and help your employees get the most value from their plan. We provide benefits management support including insightful data and guidance on issues like compliance. We provide services like care management for employees with complex medical needs, who seek cost-effective quality care, and recovery support. Our goal is to help you get the best value for your healthcare spend, year after year.

People Forward Support

- Trust your organization's health benefits to a values-based partner.
- Give employees access to compassionate care.
- Receive expert support that removes the burden of benefits management.

Rigorous stewards of your healthcare dollars

- Access to our best-in-class network.
- Protect your investments with superior payment integrity programs.
- Make informed decisions with our data-driven approach to receive the best value.

Custom and flexible plans to meet your organization's needs

- Create custom plans to match the needs of your employees and your budget.
- Choose a collaborative model that integrates efficiently with your organization.
- Flexibility on high-dollar coverage options.

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Proving What's Possible in Healthcare

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Medical Administrative Renewal*

City of Everett

Agent / Broker: Alliant Insurance Services, Inc. – Seattle

Quote Assumes an Effective Date of: January 1, 2025

Fees Based On: 1,071 Total Employees

Base Medical Administration Fees	Current	Renewal	Renewal Option
Medical Plan Administration	$17.92	$18.45	$18.45
HMA Preferred with PHCS National Network Access	$5.50	$5.50	$5.50
Care Management - Preauthorization, Large Case Management and Managed Behavioral Health Services	$3.75	$3.75	$3.75
Federal Transparency Technology Enablement Fee	Waived	$0.45	$0.45
HCBB Comply Tool	Included	Included	Included
Claim Bank Account Reconciliation	Included	Included	Included
Plan Documents (SPD and SBC)	Included	Included	Included
Stop Loss Administration**	Included	Included	Included
Total Base Administration	**$27.17**	**$28.15**	**$28.15**
Early Renewal Confirmation Credit Applies if signed renewal documents are provided by 10/31/2024		($0.20)	($0.20)
Additional Services	**PEPM Fee**	**PEPM Fee**	**PEPM Fee**
Dental Administration	$2.50	$2.50	$2.50
Dental PPO Network Access	$1.50	$1.50	$1.50
Vision Hardware Administration	$0.65	$0.65	$0.65
Care Navigator			$2.00
MDLIVE Telehealth Medical Only			$1.00
MDLIVE Mental Health, Psychiatry, and Medical Bundle			$0.35
Total Additional Services	**$4.65**	**$4.65**	**$8.00**

Care Management and COBRA

Product	Description	Price
Care Management	HMA's Care Management suite of services is an in-house program that encompasses pre-authorization, utilization management, case management, behavioral health and steerage. HMA's care management team serves members based upon their diagnosis offering full support of the member's healthcare journey, as well as oversight of plan spend. 1. Utilization Review (Prior Authorization) including Population Health, Specialty Health, Intake 2. Case Management including Member Support (Clinical), Transition of Care, Continuity of Care, and Discharge Planning staffed by our in-house, highly-skilled, certified Case Managers and Register Nurse (RN) Case Managers. • Educate members about their health and healthcare options • Ensure members receive care at the appropriate level and location • Identify and coordinate resources to support member health needs • Coordinates medication administration with providers when a client chooses our preferred PBM partner contracts • No "criteria" for Case Management support	$3.75 PEPM Required with our base administration services
COBRA Administration Services	COBRA, Continuation of Coverage, is an important part of health plan administration. It can be time consuming, and complex given today's ever-changing HIPAA compliance regulations; however, with the help of our comprehensive COBRA service and dedicated team, clients can save time and energy. we will notify participants of COBRA continuation coverage rights upon the occurrence of a qualifying event and collect premiums for continuation of coverage with distribution to vendors. All COBRA eligible benefits (Medical, Dental, Vision, FSA, EAP) are included in the administration. Online payment services for participants. See the Actuarial and Compliance product pages for rates on premium equivalent & COBRA rate calculations.	$1.35 PEPM

Care Navigation

Product	Description	Price
Care Navigator Plus	Our Care Navigator Plus builds upon all the features of our base Care Navigator product and engages members early in the plan year with a health questionnaire to collect good contact information, help identify at-risk members, and pair them with a Care Navigator who may guide them to high-quality, high-value sites of care for surgeries and imaging, in-network primary care, and partner programs. Care Navigator Plus supports the financial health of your organization by optimizing overall spend on high-cost care and improves health outcomes by empowering members at important moments in their health journeys. Clients choose between reducing the member health plan contributions or digital gift cards as an incentive for those members who complete their health questionnaire within the specified timeframe determined by the Plan. The incentive and the health questionnaire are required. We have 3 employer-funded incentive options available. 1. Employer Managed Incentive: (We will provide reporting of members qualifying for the incentive via BenefitFocus, employer assumes all liability for the incentive design and execution.) 2. $25 digital gift card automatically sent to member-provided email from Tango Platform upon employer funding of Tango account. (We set up automation, client signs 3-way agreement, then client directly funds gifts cards thru Tango.) 3. $50 digital gift card automatically sent to member-provided email from Tango Platform upon employer funding of Tango account. (We set up automation, client signs 3-way agreement, then client directly funds gifts cards thru Tango.) Member access to Healthcare Bluebook Quality and Go Green Rewards is included at no added PEPM. • Employer funds Healthcare Bluebook rewards ranging from $25-$100 when a member receives services from a fair price (green) provider. (HCBB mails a reward check directly to members. We bill clients via pass-through admin invoice for paid rewards.) • HCBB Engagement Rewards are not required. They are an available reward upgrade option with no added PEPM. • HCBB Care Connect cannot be sold with Care Nav Plus. The cost of any earned rewards and incentives are not included in the $4 PEPM.	$4.00 PEPM Plus the cost of rewards and incentives
Care Navigator	Care Navigator is our base service that supports members across their health journey. Our team acts on certain prior authorization requests to steer planned out-of-network care in-network, makes pre- and post-procedure calls, monitors utilization trends to identify opportunities for ER diversion, and educates members on plan benefits to promote utilization and support the health of your population.	$2.00 PEPM

Condition Management and Nurse Line

Product	Description	Price
Omada for Musculoskeletal	Omada for Musculoskeletal is digital physical therapy for joint and muscle health that pairs members with a 1 :1 physical therapist and leverages Advanced Computer Vision. By shifting care upstream in a member's care journey, providing clinical quality at a lower cost, and driving clinically meaningful member behaviors, Omada for MSK improves health and cost outcomes for members and employers. Patients secure an appointment within 48 hours of sign-up. Omada integrates behavioral health support into MSK and PTs can consult with a behavioral health coach as necessary. URAC top clinical accreditation for telehealth. Self-guided recovery phase and preventive program available at no cost to members.	$200 initial consultation $550 case rate for Recovery Phase (covers 12 months per injury/issue) Billed as medical claims Member cost share applies No cost for Prevention program
Disease Management	Nurse coaching and outreach for the following chronic conditions: asthma, depression, diabetes, coronary artery disease (CAD), congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and hypertension and hyperlipidemia. Client must provide and update accurate member phone numbers on eligibility file.	$3.00 PEPM first year clients only $3.50 PEPM upon renewal
Maternity Management	MommyTrax.com is a maternity and new parent benefit package that features both evidence-based health content and telehealth case management with maternity nurses. Includes a welcome kit (prenatal vitamins and a parenting book) and a $50 gift card upon program completion as incentives for participation.	$350.00 Per Case
24-Hour Nurse Line	Nurse advice line to answer health questions and assist members in selecting where and when to seek care for a particular health concern. This service is offered through our nationally acclaimed partner, CareNet.	$0.65 PEPM

Please note: MDLIVE will charge a minimum $50 no-show fee to members – this is standard practice. All MDLIVE virtual visit claims costs subject to change with 30-days notice.

Product	Description	Price
MDLIVE Telehealth Medical (Urgent Care)	We partner with MDLIVE to offer members access to board-certified doctors via secure online video or phone via our portal, the web, or the MDLIVE app – anytime, anywhere- 24/7/365. MDLIVE is a convenient alternative to urgent care visits or waiting days to get an appointment with your primary care doctor for non-emergency medical conditions. MDLIVE doctors can diagnose symptoms, prescribe non-narcotic medication (if needed and within state regulations), and send e-prescriptions to the member's pharmacy.	$1.00 PEPM Plus claim cost $42 $50 no show fee billed to members
MDLIVE Mental Health, Psychiatry, and Medical (urgent care) bundle	We partner with MDLIVE to offer members access to MDLIVE's network of licensed therapists and board-certified psychiatrists. Each provider is credentialed according to NCQA guidelines and trained on best practices in online therapy. They have a wide variety of specialties. Therapists provide guidance and support talk therapy. Online therapy provides a way to access services when it's not easy to find a therapist nearby or when therapy doesn't fit in a busy schedule. They do not prescribe medications. Psychiatrists are medical doctors who primarily prescribe medication for the treatment of behavioral health conditions. Online visits allow members to see licensed providers from the comfort of their own home. Online therapy and psychiatry visits must be scheduled in advance. You can usually get an appointment within seven days or less with a therapist compared to the average wait for in-office therapy visits of 35 days.	$1.35 PEPM Plus claim cost $42 - $160 depending on the type of service and provider level $50 no show fee billed to members
MDLIVE Virtual Dermatology and Medical (urgent care) bundle	We partner with MDLIVE to offer members access to board-certified dermatologists through a secure website or mobile device. Patients receive a full consultation, complete with a diagnosis, personalized treatment plan, and appropriate prescriptions. Members are able to avoid lengthy waits for appointments and time-consuming trips to the doctor's office. All visits are done in an asynchronous manner, unless the member's state requires a video consultation. Members simply choose Dermatology from the visit options on MDLIVE's patient dashboard. After answering a few basic questions and providing a brief medical history, the member will be asked to upload photos of the skin, nail, or hair condition. In an average of 24 hours, members are notified of a diagnosis and treatment plan from a board-certified dermatologist, which include prescriptions if necessary.	$1.30 PEPM Plus claim cost $42-$95 $50 no show fee billed to members
MDLIVE Telehealth Bundle	Combines all of the MDLIVE Telehealth benefits described above for Medical (urgent care), Mental Health and Psychiatry, and Virtual Dermatology.	$1.60 PEPM Plus claim cost $42 - $160 depending on the type of service $50 no show fee billed to members

Wellness & Behavioral Health

Product	Description	Price
Wellness Hub	Wellness and lifestyle portal: Features an extensive catalog of wellness challenges and a semi-customizable online wellness incentive tracker, a personal health assessment, a robust health library, and integration with popular fitness devices and apps.	$1.50 PEPM
Wellness Hub Incentive program set up and administration	Available only in combination with the Wellness Hub. Administrative support for Wellness Hub incentives, customized incentive campaign design, creation, management, tracking, and reporting. Standard reporting is available.	5 Hours are included Additional hours are available at $125/hour
Virtual Behavioral Health Option A	6 counseling + 6 coaching sessions per enrolled employee/family unit, per incident, per year Our virtual behavioral health product offers fast speed to appointment and therapy for conditions often excluded from health plans such as marital conflict and grief. Easy to use technology, with a personal touch. Highlights include: • Behavioral Telehealth Live Video Sessions. • Cognitive behavioral therapy. • Behavioral coaching. • Financial coaching. • Digital mental health tools. • Online Scheduling Form. • Extensive reporting.	$2.60 PEPM
Virtual Behavioral Health Option B	12 counseling + 12 coaching sessions per enrolled employee/family unit, per incident, per year Doubles the sessions for the above product description.	$3.75 PEPM

Healthcare Bluebook (HCBB)
Rewarding Healthcare Consumerism

Product	Description	Price
HCBB Quality + Go Green Rewards	Healthcare Bluebook offers a premium digital, self-service, cost and quality comparison tool making it easy for members to find the fair price for medical procedures, advanced imaging services, and the nearest and best quality providers for hundreds of inpatient procedures. Bluebook empowers members with greater visibility on cost and quality variance and protects the Plan from overpaying for health services. The 'Go Green rewards' is the base incentive program that includes 200 eligible procedures and offers reward amounts ranging from $25 - $100 per procedure. Color-coded rankings help members identify the high quality, fair price. This program rewards all members that choose a green (FairPrice) provider. Members receive check via mail.	$2.25 PEPM plus the cost of rewards Rewards are billed monthly via the fee request
HCBB Quality + Engagement Rewards	This product leverages the same HCBB cost and quality comparison tool mentioned above. The 'Engagement Rewards' is an enhanced and tiered incentive program with an expanded selection of over 400 procedures and higher reward amounts ranging from up to $350 for outpatient procedures to a max of $1,000. Color-coded rankings help members identify the high quality, fair price. This program rewards members who shop for a procedure (up to 12 months prior to date of service) and choose a green/yellow cost, green quality provider for a rewardable procedure. Members receive check via mail.	$2.25 PEPM plus the cost of rewards Rewards are billed monthly via the fee request
Healthcare Bluebook CareConnect **(Not available in combination with Care Navigator Plus, not recommended for Care Navigator)**	Care Connect: concierge service for joints, spine, and women's surgical procedures health including finding the right provider, scheduling appointment and facilitating medical record transfer. (Only available with Engagement Rewards). Requires client to provide email addresses of all eligible employees. Case rates apply for each successful steerage: ie, if the Care Connect Team steers a member to a high-value provider for a procedure that costs $5,000, the case rate due for the steerage is $700 Procedure Fair Price $3,000 - $6,999 $7,000 -$24,999 $25,000-$49,999 >$50,000 Care Connect Case Rate: $700 $1,850 $3,750 $5,500	$2.25 PEPM plus Case rates as listed per steered procedure plus Engagement Rewards up to $1500 per qualifying procedure

Consumer Driven Health – HRA/FSA Plan Options*

Plan Option	Description	Plan Price
Healthcare Reimbursement Account (HRA) Administration	Together with HealthEquity, we deliver a fully integrated approach to Health Reimbursement Account (HRA) management. This partnership provides a unique customer experience that is powerful and easy. As your partner we deliver: ▪ Complete data integration between our platform and HQY ▪ Intuitive online administration tools ▪ Educational resources ▪ Convenient, proprietary web capabilities featuring online payments and integrated claims data. ▪ Tailored communications providing clear, positive messaging that engages employees and inspires greater adoption.	$3.95 PAPM** • We charge only one PAPM fee if an individual has more than one (1) FSA and/or HRA. This does not apply to LPFSA and HSA plan type(s). • Additional fees apply - see fees page
Flexible Spending Account (FSA) Administration	Together with HealthEquity, we deliver a fully integrated approach to Flexible Spending Account (FSA) with easy enrollment, less paperwork, and hassle-free payments/reimbursements. It also means, simplified account management, online tools, resources and education; plus the dedicated service and support that distinguishes our offerings. Funds from a healthcare FSA can be used for qualified expenses including medical, dental and vision. For a full list of qualified expenses allowed by the IRS, see IRS Publication 502. **Only available with a PPO or non-Qualified Plan.**	$3.95 PAPM** • We charge only one PAPM fee if an individual has more than one (1) FSA and/or HRA. This does not apply to LPFSA and HSA plan type(s). • Additional fees apply - see fees page
Dependent Care Flexible Spending Account (DCFSA)/(DCRA) Administration	Together with HealthEquity, we deliver a fully integrated approach to Dependent Care Flexible Spending Account (DCFSA) with easy enrollment, less paperwork, and hassle-free payments/reimbursements. It also means, simplified account management, online tools, resources and education; plus the dedicated service and support that distinguishes our offerings. A dependent care FSA enables employees to set aside pre-tax dollars to pay for qualified dependent care expenses. Funds can be used to pay for day care, preschool, elderly care or other dependent care. See IRS publication 503 for additional details.	$3.95 PAPM** • We charge only one PAPM fee if an individual has more than one (1) FSA and/or HRA. This does not apply to LPFSA and HSA plan type(s) • Additional fees apply - see fees page

*** Please Note:**

- Prices subject to change with appropriate advance notice.
- Additional fees apply see HealthEquity Additional Fees page.
- Implementation requires 90 days notice for set up.
- Renewal requires new elections 30 days in advance.
- HealthEquity (HQY) must receive the eligibility from us to initiate portal setup and welcome kit creation.

**

Consumer Driven Health–HSA/LPFSA Plan Options*

Plan Option	Description	Plan Price
Health Savings Account (HSA) Administration	Together with HealthEquity, we deliver a fully integrated approach to consumer-directed healthcare that combines the industry-leading health savings account (HSA) solution with your customized health plan. It's a solution with easy enrollment, less paperwork and hassle-free claims. A health savings account, paired with an HSA-qualified health plan, allows you and your employees to make pre-tax contributions to a federally-insured account that can be used to pay for qualified medical expenses. Contributions made by you or your employees through payroll deductions result in FICA and income tax savings. HSA balances earn tax-free interest and roll over from year to year. HSA-qualified health plans typically cost less than traditional plans and the money saved can be deposited into an HSA for immediate use or long-term savings.	$2.70 PAPM* • HSA accounts coupled with an LPFSA will be billed $4.65 PAPM ($2.70 PAPM for HSA + $1.95 PAPM for LPFSA) • Additional fees apply - see fees page
Limited Purpose Flexible Spending Account (LPFSA) Administration	Together with HealthEquity, we deliver a fully integrated approach to Limited Purpose Flexible Spending Account (LPFSA) with easy enrollment, less paperwork, and hassle-free payments/reimbursements. It also means, simplified account management, online tools, resources and education; plus the dedicated service and support that distinguishes our offerings. An LPFSA used in conjunction with a health savings account (HSA) allows employees to contribute additional pre-tax dollars to use for dental and / or vision expenses. This allows users to maximize their pre-tax contributions to an HSA and contribute additional pre-tax dollars to an LPFSA. **Only available with a qualified HDHP.**	$1.95 PAPM** * LPFSA accounts coupled with an HSA will be billed $4.65 PAPM ($1.95 PAPM for LPFSA + $2.70 PAPM for HSA) • Additional fees apply - see fees page

*** Please Note:**

- Prices subject to change with appropriate advance notice.
- Additional fees apply see HealthEquity Additional Fees page.
- Implementation requires 90 days notice for set up.
- Renewal requires new elections 30 days in advance
- HealthEquity (HQY) must receive the eligibility from us to initiate portal setup and welcome kit creation.

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HealthEquity Additional Fees*

HealthEquity Annual Fees for our contract. Fees invoiced by and paid directly to HealthEquity.

Description	Fee
HRA / FSA / DCFSA / LPFSA – Plan set up and annual Plan maintenance fee applied per plan type and invoiced annually through the HealthEquity employer portal.	$250 for groups with less than 1000 benefit eligible employees (EEs) $500 for groups with more than 1000 benefit eligible employees (EEs)

HealthEquity additional employer fee disclosures:

Employer fees for atypical transactions	Fee
Return Deposit	$20 per transaction
Employer Contribution Refund Request	$20 per transaction
Manual Contribution Processing (no fee if instructions are submitted online or via electronic file)	$20 per event

Member/Account Holder Fee disclosures:

(Fees subject to change with appropriate advance notice)	
HealthEquity Visa Card	Up to 2 FREE Additional/replacement cards are $10 per card
Electronic Statement	FREE
Paper Statement (avoided with Electronic Statements)	$1.50 per monthly statement
Card Transaction	FREE
Payment to Provider	FREE
Electronic Payment to Self	FREE
Paper Check to Self	$2.00 per transaction
Investment Trades	FREE
Investment Account creation (but see other investment related fees below)	FREE - Note: A cash balance of at least $1,000 is required to invest in mutual funds
Stop Payment Request	$20.00 per request
Overdrawn account or Non-Sufficient Funds	$20.00 per transaction
Distribution of Excess Contribution (initiated by member)	$20.00 per request
Return Deposit	$20.00 per transaction
Account Closing	$25.00 one-time fee
Investments Related Fees	
Investor Choice Funds instead of standard HQY fund line up	0.0333% per month on dollars invested in Investor Choice funds (0.40% per year)
Advisor GPS Service	0.05% per month on invested dollars (0.60% per year)
Advisor Auto Pilot	0.08% per month on invested dollars (0.96% per year)

*** Please Note:**

- Prices subject to change with appropriate advance notice
- Implementation requires 90 days notice for set up.
- Renewal requires new elections 30 days in advance.
- HealthEquity (HQY) must receive the eligibility from us to initiate portal setup and welcome kit creation.

This document contains important terms and conditions which are incorporated by reference into and becomes part of the terms of your contract with us.

Actuarial and Compliance Services

Actuarial Testing / Calculation	Description of Service	Price
PACE Fiduciary Service	The PACE Fiduciary Service provides final appeal determination decisions on behalf of the plan. The Fiduciary Service is provided by the Phia Group*, an expert in self-funded legal services. With PACE, Phia reviews adverse benefit decisions made by the plan and acts as the plan's fiduciary to make final appeal determination on the plan's behalf. In addition, the Phia Group takes on liability for damages that may result from an arbitrary or capricious claims determination.	$2.10 PEPM
Part D Creditable Coverage	Determination of employer prescription drug coverage meeting Medicare's Creditable Coverage Requirements. Fees are per Plan tested.	$468
Premium Equivalent & COBRA Rate Calculation (Medical)	Calculation of premium equivalent rates & COBRA premiums for Medical Plans (including pharmacy) in "Short Form" report format for up to 3 Plans. "Long form" report format is available for $500 per Plan. Additional Plans subject to additional fees - $1,500 per Plan.	$4,675
Premium Equivalent & COBRA Rate Calculation (Dental)	Calculation of premium equivalent rates & COBRA premiums for Medical Plans (including pharmacy) in "Short Form" report format for up to 3 Plans. Additional Plans subject to additional fees - $600 per Plan.	$2,200
Premium Equivalent & COBRA Rate Calculation (Vision)	Calculation of premium equivalent rates & COBRA premiums for Medical Plans (including pharmacy) in "Short Form" report format for up to 3 Plans. Additional Plans subject to additional fees - $400 per Plan.	$1,375
IBNR Reserve Calculation (Medical)	Calculation of liability for claims incurred but not yet reported (IBNR). Fees are per calculation.	$1,375
IBNR Reserve Calculation (Dental)	Calculation of liability for claims incurred but not yet reported (IBNR). Fees are per calculation.	$990
IBNR Reserve Calculation (Vision)	Calculation of liability for claims incurred but not yet reported (IBNR). Fees are per calculation.	$825

We may receive revenue cost-share from vendor who provide services to the Plan Sponsor through our vendor contract.

Actuarial and Compliance Services

Actuarial Testing / Calculation	Description of Service	Price
Recommended Claims Fluctuation Reserve Calculation	Calculation of recommended level of assets necessary to fund the reserve for claims fluctuations. Fees are per calculation.	$1,100
NQTL Mental Health Comparative Analysis	If you are interested in this service, due to the complexity of the requirements a custom proposal will need to be created for each client by our partner MZQ. For additional information see the product sheet and contact your Account Executive.	Custom upon request
NQTL Mental Health Comparative Analysis Data Only	The Data Only Product includes: The Plan's claim utilization data for the benefits we administer, Claims utilization data for clients accessing pharmacy benefits through one of our PBM contracts, Supplemental TPA, Network, and Care Management Informational Materials Does not include Claims data or materials for any other benefits administrator or carve out product, Rx/PBM claims not on our preferred PBM contract. This is data only and does not include the Comparative Analysis.	$2,000
Section 105(h) Non-Discrimination Testing	Completion of annual test to confirm compliance with Section 105(h) requirements. Fees are per calculation.	$1,375
ACA Support Services Buy Up Option 1 -- 1094 & 1095 Filing Service	ACA Support Services to assist clients in calculating, defining and reporting the necessary data, including filing the necessary 1094-C and 1095-C forms. The service includes: • Employer Mandate Consulting with an ERISA attorney • 1095-C Benefit Information Reporting • Production & E-filing with the IRS of Form 1094-C • Production & E-filing with the IRS of Form 1095-C (employee form, also called the individual statement) provided to employer in electronic format for distribution to employees • Printing and mailing of Form 1095-C to employees (optional – additional fees apply)	$4,000 Per Client + $500 For Each Additional Employer Identification Number (EIN) + $9-$15 (fee varies based on employer size) Statement Fee Per Employee Form including Printing and Mailing.
ACA Support Services Buy Up Option 2 - Full Time Employee Tracking & Calculation	ACA Support Service to identify full-time employees. This annual service provides reporting for both current employees and new hires to determine if, based on variable hours or fluctuating work schedules, they qualify as full-time under the employer mandate.	Annual Tracking - $10 Per Employee Per Year with a Minimum of $2,000 and a Maximum of $7,500 Monthly Tracking - $500 per Month
MA-1099 Filing		Waived

We may receive revenue cost-share from vendor who provide services to the Plan Sponsor through our vendor contract.

Stop Loss Contract Highlights

PLEASE REFER TO THE STOP LOSS QUOTE FOR INFORMATION ON CONTRACT FEATURES, CONTINGENCIES AND POSSIBLE LASERS

We understand there are many stop loss carriers in the market and rates are only one of the many important factors to consider in carrier selection. Understanding policy provisions between carriers and underwriting practices of stop loss carriers can vary and should be considered prior to purchase. Renewal guarantees and no laser options may be available. Please review a carrier's formal stop loss proposal for the terms that apply to your quote and for any contingencies or caveats to bind coverage.

Through our review and evaluation process, we have deemed several stop loss carriers to be preferred. We value our long-term relationships between our Care Management and Claims Operations teams, and our preferred stop loss partners. We have built efficiencies to facilitate more reliable reimbursement of stop loss claim violations and shared agreements on the following:

- Discounting rates based on Disease Management and Maternity Management programs
- Shared reporting requirements
- Synergy with our Case Management and Utilization Review
- Mitigation of potential claims payment disagreements
- Ease of invoice billing and reconciliation
- Compensation in the form of an override for the services we provide on behalf of our clients

HMA can support you with shopping the stop loss market by requesting stop loss proposals from our preferred carrier partners. Please notify your account manager if you would like our assistance.

Direct Contracts (no intermediary)	MGU's
Sun Life Financial HM Insurance Group QBE Insurance Corporation Symetra Financial Tokio Marine HCC Physicians Insurance Commencement Bay Risk Managers SwissRe Voya Financial Berkshire Hathaway	ISU w/ Companion Medical Risk Managers (MRM) Starline iiSi

Please note, if the client desires to work with a stop loss carrier or third-party service, which is not currently included in our preferred carrier list, you must notify us upfront.

We reserve the right to decline to work with non-preferred stop loss carriers, MGU's, GA's and Captives. If we agree to administer a plan with a stop loss carrier that is not preferred, we will charge an interface fee of $3.50 PEPM.

For carriers where we are not an approved benefit administrator, we reserve the right to decline to proceed with the approval process at our discretion.

CVS/caremark™

Pharmacy Benefits*

CVS Health is one of the largest Pharmacy Benefit Managers in the United States and one of the leading PBMs in the self-funded insurance industry. We contract with CVS/Caremark to offer high-quality affordable prescription benefits. Clients may choose between a range of formularies designed to address each client's benefits strategy and deliver the lowest net cost.

Effective in January 2024, CVS Health partnered with GoodRx to introduce a new Cost Saver program. This program is included at no cost to the client or member and runs as a behind-the-scenes, real-time program so the member receives the lowest net price while at a network pharmacy on a selection of medications.

Rates as follows are for clients on our contract and are effective January 2025 – December 2025.*

Pharmacy Pricing and Fee Components	
Retail Non- Specialty Pharmacy – National Network	**PPO or HDHP**
National Network Brand Discount	AWP – 19.00%
Retail 90 Day Network Brand Discount	AWP –19.25%
Generic - Flat Discount	AWP – 86.00%
Dispensing Fee National Network-Brand and Generic per Claim	$0.40
Dispensing Fee Retail 90 Day-Brand and Generic per Claim	No Dispensing Fee
Mail Order/Maintenance Pharmacy	**PPO or HDHP**
Brand- Flat Discount	AWP – 25.00%
Generic - Flat Discount	AWP – 88.50%
Dispensing Fee Brand and Generic per Claim	No Fee
Specialty at Retail	**PPO or HDHP**
Brands	AWP – 17.5% + $0.40 Dispensing Fee
Generic	AWP –40.00% + $0.40 Dispensing Fee
Specialty at Retail Limited Distribution Drugs (With & Without Access)	AWP – 10.00% + $.0.40 Dispensing Fee
Client-Owned Pharmacies	**PPO or HDHP**
Brand	Pass Through Rates and Fees
Generic	Pass Through Rates and Fees
Dispensing Fee	Pass Through Rates and Fees
Mail/Maintenance Choice	**PPO or HDHP**
Brand	AWP- 19.50%
Flat Generic Discount	AWP- 91.75%
Dispensing Fee (Brand & Generic)	$0.00 per claim
Administrative Fees	**PPO or HDHP**
Client Owned Pharmacy Administration Fee	$1.50 per claim
Electronic Claim Administration Fee	$0.00 per claim
Manual Claim Administration Fee	$1.50 per claim

***Please Note:**

- Other fees, terms and conditions apply – please see the CVS/Caremark Add'l Fees, Pricing, Terms & Condition section.
- Please see Participating Group Agreement and supplement documents for full Terms and Conditions.
- Standard implementation requires a minimum of 100 days prior written notice. PrudentRx requires a minimum of 130 days prior written notice.

CVS/caremark™ Pharmacy Benefits

Rates as follows are for clients on our contract and are effective January 2025 – December 2025.*

Pricing for Specialty drugs listed on CVS's Specialty Fee Schedule	
	Discount Rate
Exclusive	AWP - 21%
Open	AWP – 17%
New to Market Brand & Generic Drugs	AWP -15%
New to Market limited and exclusive distribution drugs	AWP – 10%
Dispensing fee	$0.00

Specialty Drugs" means certain pharmaceuticals, biotech or biological drugs (including "biosimilars" or "follow-on biologics") that are Covered Products and that are defined by CVS Caremark, that are used in the management of chronic, complex, rare or genetic disease, including but not limited to, injectable, infused, inhaled or oral medications, or products that otherwise require special handling, including without limitation those on CVS's Specialty Fee Schedule (which CVS Caremark may amend from time to time). The rates quoted herein apply to Specialty products dispensed from CVS Specialty mail pharmacies, including through the Specialty Connect process.

Rebates as follows are for clients on our contract and are effective January 2025 – December 2025.*

Rebates	
Standard Control Choice Formulary	**2 Tier Qualifying, 3 Tier Non-Qualifying, & 3 Tier Qualifying (per brand claim)**
Retail	$365.00
Specialty at Retail	$365.00
Mail/Maintenance Choice	$789.00
Specialty at CVS Health Specialty	$3690.00
Advanced Control Specialty at CVS Health Specialty	$3763.00
Advanced Control Choice Formulary	**2 Tier Qualifying, 3 Tier Non-Qualifying, & 3 Tier Qualifying (per brand claim)**
Retail	$372.00
Specialty at Retail	$372.00
Mail/Maintenance Choice	$804.00
Advanced Specialty at CVS Health Specialty	$3763.00
Basic Control Formulary	**2 Tier Qualifying, 3 Tier Non-Qualifying, & 3 Tier Qualifying (per brand claim)**
Retail	$310.00
Specialty at Retail	$310.00
Mail/Maintenance Choice	$670.00
Specialty at CVS Health Specialty	$3136.00
Advanced Control Specialty at CVS Health Specialty	$3763.00
Standard Opt-Out Formulary	**2 Tier Qualifying, 3 Tier Non-Qualifying, & 3 Tier Qualifying (per brand claim)**
Retail	$292.00
Specialty at Retail	$292.00
Mail/Maintenance Choice	$631.00
Specialty at CVS Health Specialty	$2952.00
Advanced Control Specialty at CVS Health Specialty	$3763.00

***Please Note:**

- Other fees, terms and conditions apply – please see the CVS/Caremark Add'l Fees, Pricing, and Terms & Condition section.
- Please see Participating Group Agreement and supplement documents for full Terms and Conditions.
- Standard implementation requires a minimum of 100 days prior written notice. PrudentRx requires a minimum of 130 days prior written notice.

CVS/caremark™ Pharmacy Benefits

Additional Fees as follows are for clients on our contract and are effective January 2025 – December 2025.*

Additional Fees	
Description	**Price**
Manual Eligibility Submission	$1.00/ Manual Entry
Manual/Paper Claim Submissions	$1.50/ Per Processed Claim
Client Specific Programing	$150.00 per hour
RxDC Reporting Filing Fee	$0.02 PMPY
Rx MRF Fees	Fees to be established and will be passed through to client
Transparent Network Fees [1]	$1.50 Per Claim
State Regulatory Impact Assessment[2]	$0.51 per retail claim only
Misc. Fees	
Description	**Price**
Prior Authorization	$30.00 per Prior Authorization
State Regulation required denial oversight by Physician for Prior Authorization Request (per request)	$45.00 Internal CVS Caremark Physician $55.00 External Physician
External Review	$500.00 per IRO external review requested
Specialty Guideline Management	$30.00 per review (Open-Formulary) $0.00 per review (Exclusive Specialty)
Formulary Exception	$30.00 per request
Vaccine Program Management fee	$0.05 per member per month
Vaccine Administration fee	$20 per vaccine claim
Shipping of temperature sensitive medications	$22 per non-specialty mail temperature sensitive
Appeals Fees	
Description	**Price**
1st Level Appeals	$100.00 per review
2nd Level Appeals	$500.00 per review
Urgent 1st Level Appeals with an IRO	$600.00 per review
Retail Network Pharmacy 3rd Party Appeal	Pass through fees per review

***Please Note:**

- Other fees, terms and conditions apply – please see the CVS/Caremark Add'l Fees, Pricing, Terms & Condition section.
- Please see Participating Group Agreement and supplement documents for full Terms and Conditions.
- Standard implementation requires a minimum of 100 days prior written notice. PrudentRx requires a minimum of 130 days prior written notice.

1 -States that require a Transparent Network will be billed $1.50 per claim in those states. Current states that require a Transparent Network include: FL, TN, WV, OK, AR (subject to change)

2- Applies to claims in select states with relevant regulatory requirements. The current list of states includes AL, AR, AZ, CO, DE, FL, GA, IA, LA, MD, MI, ND, NM, OK, SD, MS, NJ, TN, VA, TX, WA, WV, WY and is subject to change.

CVS/caremark™

Pharmacy Benefits

Additional Fees as follows are for clients on our contract and are effective January 2025 – December 2025.*

Additional Fees	
File Fees	
Description	**Price**
Refill Transfers	$4,5000.00 for 1 test file and two production files $1,500.00 for separate pre transition file.
Prior Authorization	$3,500.00
Claims History	$2,500.00 12 months worth of data
Account Balances	$2,500.00
Historical Claims Experience Transactions/CET data	Previous 24-month period: $125.00 per month up to $3,000.00 After 24-month period: $1,250.00 per quarter, $5,000.00 per year
Fees may apply for standard on-going claim files for additional vendor file feeds	Quoted upon request

Communication Fees (Fees only apply when Participating Group opts into or requests outreach to their members.)	
Description	**Price**
Negative formulary change letters, Pharmacy termination service, network disruption, Notice of Creditable Coverage (NOCC), and other mailings in black/white up to 4 pages.	$1.35 per letter plus postage
Other mailings, including color, 5+ pages, custom letters, payroll stuffers, etc..	Quoted upon request
All member communications sent digitally – (except for ID cards which are included at no cost)	$0.75 per letter

***Please Note:**

- Other fees, terms and conditions apply – please see the CVS/Caremark Add'l Fees, Pricing, Terms & Condition section.
- Please see Participating Group Agreement and supplement documents for full Terms and Conditions.

CVS/caremark™ Pharmacy Benefits

Additional Fees as follows are for clients on our contract and are effective January 2025 – December 2025.*

Core Clinical Services and Programs** **Please note that all items are available but will need to be opted in to by the Participating Group.	
Description	**Cost**
Formulary Management	No Additional Cost
Safety Programs	
POS Safety Review	No Additional Cost
Retrospective Safety Review with Pharmacy Claims	No Additional Cost
Physicians Profiling Report	No Additional Cost
POS Utilization Management, Dose Optimization, Quantity Limit, Step Therapy	No Additional Cost
Savings Programs	
Comprehensive Generics Solutions, DAW Solution 1 and or 2, Value Drug Savings Tool, DAW Penalty	No Additional Cost
POS Preferred Product Messaging	No Additional Cost
Generic Step Therapy (Prior Auth fee will apply)	No Additional Cost
Pharmacy Advisor	No Additional Cost
Pharmacy Advisor Support: Adherence	No Additional Cost
Pharmacy Advisor Support: Ready Fill at Mail	No Additional Cost
Pharmacy Advisor Support: Closing Gaps in Medication Therapy	No Additional Cost

Specialty Drug Savings Program: PrudentRx

CVS Caremark has partnered with PrudentRx to deliver additional savings on specialty drugs. PrudentRx is a vendor that uses a coinsurance flat rate of 30% for all specialty medications exclusively dispensed by CVS Specialty Pharmacy, ensuring clients pay a lower cost and members pay $0.00 out of pocket.

PrudentRx works in conjunction with CVS Caremark's Advanced Control Specialty Formulary (ACSF) to offer the most optimal savings for clients. The ACSF is required for opting in to PrudentRx. This is not required at the time of implementation and can be implemented as a stand alone at each quarter of the year (January, April, July, October) and takes 90 days to implement.

Caremark Cost Saver™ The pricing in this document assumes the use of the Caremark Cost SaverTM program, under which CVS Caremark may compare the price available under the CVS Caremark contracted network with the price available through a non-CVS Caremark contracted network if available for that pharmacy. If the price is lower through a non-CVS Caremark contracted network (including an administrative fee paid to the third-party that contracts the network), the Claim will be processed through that network. These Claims are included in the reconciliation of all financial guarantees. In these instances, the generic drug prescription through retail may be less than the same generic drug, dosage form, and dose through mail on the same day of adjudication.

* **Please Note:**
- Other fees, terms and conditions apply – please see the CVS/Caremark Add'l Fees, Pricing, and Terms & Condition section.
- Please see Participating Group Agreement and supplement documents for full Terms and Conditions.
- Standard implementation requires a minimum of 100 days prior written notice. PrudentRx requires a minimum of 130 days prior written notice.

CVS/caremark™ Pharmacy Benefits

Additional Terms and Conditions as follows are for clients on our contract and are effective January 2025 – December 2025.*

CVS Formularies (high-level descriptions) :

- **Standard Opt-Out:** The most open formulary that CVS Caremark offers. This formulary less rebates in exchange for a broader list of available drugs covered under the formulary.
- **Basic Control:** Formulary option that is slightly more restrictive than Standard Opt-Out. Offers more rebates, but less drugs are covered under the formulary.
- **Standard Control Choice:** CVS Caremark's standard formulary that offers optimum rebate savings, but a balance of drugs covered under the rebate.
- **Advanced Control Choice:** Most restrictive formulary CVS Caremark has to offer. This formulary offers the most rebate savings and less coverage of drugs on the formulary.

The formularies above, with the exception of the Standard Formulary Opt-Out, include certain preferred brand drugs where the Tier 1 cost share shall be assessed to members. CVS publishes quarterly updates to each formulary.

Formulary Terms and Conditions:

Step Therapy:

- Participating Group shall adopt CVS Caremark's generic step therapy plans (hereinafter referred to as the "GSTP Program"), as amended from time to time by CVS Caremark, as part of its Plan design.
- Participating Group receiving the GSTP pricing directs CVS Caremark to implement the coverage limitations, generic substitutions, step-therapies or prior authorizations for the therapeutic classes as identified in the PDD.
- Participating Group receiving the GSTP pricing above fails to adopt the GSTP Program conditions or otherwise qualify for the GSTP Program, then CVS Caremark reserves the right to modify the financial terms of this Agreement, including any financial guarantees.
- Participating Groups will need to approve any amendments on any Plan documents, as it deems appropriate, to reflect the GSTP Program as part of its benefit.

Voluntary Maintenance Choice:

- Participating Group's who adapt the voluntary Maintenance Choice Program requires a plan design that requires Cost Share for Maintenance Choice Prescription to be the same or similar as the Cost Share (copayment or coinsurance) for the same days' supply at mail to provide an incentive for participants to move to a 90-day supply, allows CVS Caremark to communicate with plan participants regarding the benefits of moving to a 90-day supply consistent with the plan design and limits the ability of participants to receive 90-day supplies to CVS Caremark Pharmacy retail locations and CVS Caremark mail service only.
- The Program applies only to "Maintenance Choice Prescriptions".
- Pricing discounts and dispensing fees will be the same whether the plan participant fills their prescription at a retail location or in mail order.
- CVS Caremark may modify or suspend the Program with written notice to the Participating Group.

Maintenance Choice All Access:

- Maintenance Choice All Access provides plan participants with prescription delivery from a local CVS Retail pharmacy at a reduced rate.
- Participating Groups will receive a program credit from CVS Caremark which will be applied to reduce the delivery fee charged by CVS Caremark Pharmacy.
- The program credit shall constitute and shall be treated as discounts against the price of drugs within the meaning of 42 U.S.C 1320a-7b
- Pricing discounts and dispensing fees will be the same whether the plan participant fills their prescription at a retail location or in mail order.
- CVS Caremark will provide Participating Group with an additional discount off the price of drugs dispensed under the Agreement (the "Program Credit").
- Participating Group agrees to allow CVS Caremark to communicate with Plan Participants regarding the features of the Program.

Retail Network:

- National Network as well as the CVS Caremark Retail 90 Network is available for Participating Groups.

*** Please Note:**

- Please see Participating Group Agreement and supplement documents for full Terms and Conditions.

Additional Terms and Conditions as follows are for clients on our contract and are effective January 2025 – December 2025.

2025 additional pricing, terms and conditions

Definitions:
"Rebates" means the formulary rebates received by CVS Caremark from various pharmaceutical companies whether directly or indirectly including in CVS Caremark's capacity as a group purchasing organization for the Plan that are attributable to the utilization of Covered Products by Plan Participants.

"Brand Drug" shall mean drugs or devices for which the Medi-Span Multisource Code field contains "M" (co-branded product), or "N" (single source brand), or "O" (originator). For purposes of adjudication, in limited circumstances, CVS Caremark may override the M, N, or O indicators and deem the drug to be a Generic Drug after a review of additional information including other Medi-Span data, FDA application data (NDA/ANDA) and price.

"Generic Drug" shall mean drugs or devices for which the Medi-Span Multisource Code field contains a "Y" (generic). Claims with DAW 5 code ("House Generics") shall also be classified as Generic Drug Claims. For purposes of adjudication, in limited circumstances, CVS Caremark may override the M, N, or O indicators and deem the drug to be a Generic Drug after a review of additional information including other Medi-Span data, FDA application data (NDA/ANDA) and price.

Specialty Drugs" means certain pharmaceuticals, biotech or biological drugs (including "biosimilars" or "follow-on biologics") that are Covered Products and that are defined by CVS Caremark, that are used in the management of chronic, complex, rare or genetic disease, including but not limited to, injectable, infused, inhaled or oral medications, or products that otherwise require special handling, including without limitation those listed on CVS's Specialty which CVS Caremark may amend from time to time."

"3408 Claim" means a Claim identified by the submission of "20" in any of the Submission Clarification Code fields and/or a Claim submitted by pharmacy owned by a covered entity, as defined in Section 340B(a)(4) of the Public Health Services Act, whose 340B status is coded as "38" or "39" in the NCPDP DataQ database. 1.32.

"Specialty Connect" means a convenience offering of CVS Caremark where, subject to applicable law, a Plan Participant may submit a Specialty Drug prescription to a CVS Specialty Pharmacy through any CVS retail pharmacy. In addition, where permitted by law, CVS Specialty Pharmacy prescriptions can be picked up at any CVS retail pharmacy."

"Biosimilar" means a biological product that is highly similar to a biological product already approved by the FDA (i.e. reference product) and is licensed and approved by the FDA as a Biosimilar notwithstanding minor differences in clinically inactive component but otherwise no meaningful differences between the biologic product and the reference products in terms of safety, purity and potency of the product.

* **Please Note:**
- Please see Participating Group Agreement and supplemental documents for full Terms and Conditions

CVS/caremark™ Pharmacy Benefits

Additional Terms and Conditions as follows are for clients on our contract and are effective January 2025 – December 2025.*

2025 additional pricing, terms and conditions:

- Participating Groups may not have any direct or indirect agreement or arrangement with any pharmaceutical company or other third party related to any rebates or discounts.
- Participating Groups acknowledge that CVS Caremark shall be the exclusive PBM and related PBM services.
- Participating Group will be required to sign a Participating Group Agreement which allows CVS Caremark and us to act on behalf of the Participating Group and engage with CVS Caremark as the pharmacy benefits manager (PBM).
- Participating Group's retail networks include the CVS National Network as well as the CVS Caremark Retail-90 Network as its. In the instance where a Participating Group chooses the Retail-90 Network in place of the National Network, the following shall apply: The CVS Caremark Retail-90 Network is a subset of the National Network which provides a flexible option of a nationwide network of retail pharmacies that can fill up to a 90 days' supply of medications. CVS Caremark Retail-90 Network pricing is applicable for non-specialty claims equal to or greater than an 84 days' supply filled by a participating CVS Caremark Retail-90 Network pharmacy. Claims up to the Participating Group's qualified retail days' supply plan design limits can be filled at any participating pharmacy. Claims greater than Participating Group's qualified retail plan design limits shall only be filled by a CVS Caremark Retail-90 Network pharmacy. Implementation of Maintenance Choice and/or a mandatory plan design may limit the implementation of this offering.
- The participating pharmacy may collect from the member the lowest of the discounted cost, applicable cost share, or the participating pharmacy's usual and customary price.
- All pricing in this document is available to our new clients that become Participating Groups on and after the effective date of this document and to existing Participating Groups on the effective date.
- If a Participating Group terminates either their PBM contract thru us or terminates with us altogether, and has passed runout, the Participating Group will be responsible for paying directly to CVS Caremark any Medicare or Medicaid claims that are billed up to three (3) years after date of service.
- Custom mailing requests to assist a Participating Group on a plan participant mailing project, current postage rate could apply.
- If elected by Participating Group, CVS Caremark may provide to Plan Participants filling prescriptions at Participating Pharmacies discounts on prescription drugs that are not Covered Products. Claims that process with such discounts are excluded from any and all commitments CVS Caremark may have to Participating Groups under this agreement including those relating to pricing, rates or rebates. The Participating Group acknowledges that CVS Caremark will retain rebates, if any, and charge Plan Participant fees that may be part of a Plan Participant's prescription price for claims processed through this program to assist CVS Caremark in funding this program.
- Appeals: Determination of Prescription Benefit Coverage and Eligibility; Independent Physician Specialist Review or IRO (Independent Review Organization) External Review (See Appeals FeeTable)
- Participating Group requested audits are not available under our Caremark Agreement. Any client requests for individual audits of Caremark may be considered on a case-by-case basis subject to Caremark's approval. If such request is approved, Participating Group must pay any fees assessed by Caremark and pay for a Caremark-approved independent auditor.
- In the event Participating Group terminates Administrative Services Agreement with us, we may use pharmacy rebates as a set-off against amounts due to us from Participating Group or may delay remittance of these rebates to allow for final adjustments.
- Participating Group acknowledges that CVS Caremark provides an administrative credit to us in compensation for the services provided including enrollment processing, invoice processing and customer service among other duties. We have credited the Medical Administration fee by $2.00 PEPM under this acknowledgement. We have also considered the receipt of this administrative allowance in the calculation of the Plan's TPA fees.

*Please Note:

- Please see Participating Group Agreement and supplemental documents for full Terms and Conditions

Additional Terms and Conditions as follows are for clients on our contract and are effective January 2025 – December 2025.

2025 additional pricing, terms and conditions

- CVS Caremark shall make available to us information reflecting the amount of payments that have become due with respect to each Participating Group.
- If any payment required by the Participating Group is not received by CVS Caremark in the manner and time frame communicated by us or otherwise set forth herein, CVS Caremark, may in accordance with the agreement with the Participating Group, charge late fees, withhold amounts from the security deposit, if any, cease or suspend performing services or otherwise terminate this Participating Group Agreement in accordance with the terms.
- Participating Group shall have no right to offset from payments due hereunder disputed amounts or amounts due or allegedly due from CVS Caremark, except as approved in writing by CVS Caremark. Any sales, use or other tax assessment, including any surcharge or similar fee imposed under any applicable law on any health care provider, Plan Participant, service, supply or product provided under us and/or the Participating Group Agreement shall be the sole responsibility of the Participating Group as applicable and may be added to the invoice.
- Discount and dispensing fee guarantees are based upon fully-funded Plan designs and apply to all paid Claims with the exception of the following exclusions: 340B Claims; Compound drug Claims; Paper or Member submitted Claims; Coordination of Benefits (COB) or secondary payor Claims; Claims paid at government required amounts; Vaccine and vaccine administration Claims.
- Participating Pharmacy rates may vary and the amount paid by CVS Caremark to the Participating Pharmacy may not be equal to the amount billed to Administrator and CVS Caremark shall retain and not disclose to any third party, including Administrator, any difference. However, in states requiring a transparent network, the amount billed to the Administrator will be equal to the amount paid to the Participating Pharmacies and CVS Caremark will apply a $1.50 Administration Fee per retail Claim in those states.
- CVS Caremark shall provide quarterly notices regarding any negative changes to the Formulary, which may include, but are not limited to, movement of a drug from a preferred to a non-preferred tier, or the addition of or removal of utilization management edits.
- CVS Caremark shall use reasonable efforts to provide such notice at least sixty (60) days prior to such change.
- In the event of a removal of a drug from the Formulary, CVS Caremark shall provide targeted communications to Plan Participants prior to the date of removal.
- At Participating Group's request and expense, CVS Caremark may prepare and provide non-standard management and utilization reports and ad hoc reports within an agreed upon time and format, at CVS Caremark's prevailing rate.
- CVS Caremark allows that any fees charged by CVS Caremark in association with machine readable files and/or compliance reporting, in addition to any other fees associated with mandated transparency requirements,
- may be passed to Participating Groups.
- Participating Group, shall provide CVS Caremark with sixty (60) days prior written notice of any proposed changes to the PDD, or other material Plan amendments that may impact prescription drug coverage under the Plan.
- CVS Caremark may, but shall not be obligated to, dispense a prescription even if the prescription is not accompanied by the Cost Share.
- CVS Caremark will credit any amount submitted by Plan Participant in excess of the Plan Participant's Cost Share.
- In the event a Plan Participant submits to CVS Caremark an insufficient Cost Share and the Plan Participant fails to remit the balance of the Cost Share amount to CVS Caremark within thirty (30) days of CVS Caremark's request, then CVS Caremark shall have the right to invoice Participating Group.
- Non-Specialty Claims dispensed by a CVS Specialty Pharmacy will price as a Retail Non-Specialty Claim.

* **Please Note:**
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Additional Terms and Conditions as follows are for clients on our contract and are effective January 2025 – December 2025.

2025 additional pricing, terms and conditions

- Each Participating Group shall have sole financial responsibility for the payment of Claims for benefits rendered.
- Payments not received shall bear a service fee of one percent (1%) per month (or, if less, the highest rate allowed by law), from the due date until paid in full.
- Participating Group shall provide CVS/Caremark with a current and accurate copy of the Plan Document, concerning Plan design, prescription drug benefit planning, eligibility, benefits to be provided, limitations and claim review and procedures.
- Participating Group acknowledges that Participating Group's use of the Program may impact the Agreement and underwriting assumptions, including Rebates.
- Neither your Administrator nor CVS Caremark will be liable for any loss, expense, cost, liability, damages or claims incurred by Participating Group as a result of Participating Group's Program, including but not limited, to the IRS' disallowance of any drug claim that bypassed a HDHP deductible through Participating Group's Program.
- Participating Group accepts and adopts the Preventive Care Drugs List as a part of Participating Group's plan design to be administered by CVS Caremark.

- Financial Responsibility. If at any time during the Plan term, Participating Group fails to comply with the payment terms as set forth in related agreements and the Participating Group Agreement on three (3) or more occasions within a four (4) month period, then CVS Caremark may request information, reasonable assurances or both from Participating Group as to Participating Group's financial responsibility (including a deposit in an amount equal to two (2) billing cycles based upon the average of the last three (3) months of billing history).

Specialty:

- Non-specialty medications dispensed by the specialty pharmacy will receive standard retail 30-day supply rates.
- Prior Authorization, $30.00 per PA; fee doesn't apply to specialty drug claims when Participating Group with Exclusive CVS Specialty pharmacy elects Specialty Guideline Management (SGM) program.
- Instances in which Administrator's Participating Groups elect Exclusive Specialty, CVS Specialty mail pharmacies, including Specialty Connect, will be the exclusive provider of specialty pharmacy services. Claims for specialty products will not be processed through the retail network, except for those specialty drugs that CVS Specialty mail pharmacies are unable to dispense.
- Limited Distribution Drug" means a Covered Drug that is distributed by a limited number of specialty
- pharmacy providers as determined by exclusive or preferred vendor arrangements with the pharmaceutical
- Manufacturer.
- In the event of an industry-wide product shortage, CVS Caremark reserves the right to adjust pricing upon notice to the Participating Group.

Specialty Per Diems:

- Remodulin, Veletri, Flolan, Epoprostenol Sodium & Treprostinil Sodium & Zulresso for Injection: $60 per day.
- Ventavis: Participating Group acknowledges and agrees an I-Neb is necessary for the administration of Ventavis.
- For each I-Neb provided to Plan Participant, upon the initiation of therapy or in the event a replacement 1-Neb is necessary, Participating Group shall reimburse CVS Caremark $1,811 for each I-Neb.
- Unless otherwise stated above: $75 per dose.
- Nursing Charges: $225.00 per visit up to 2 hours, $110.00 for each hour thereafter.
- Alternatively, CVS Caremark can refer any medically necessary nursing services to the Participating Group's contracted nursing agency, in which case nursing services will be billed separately by those agencies.

*** Please Note:**

- Please see Participating Group Agreement and supplemental documents for full Terms and Conditions

Additional Terms and Conditions as follows are for clients on our contract and are effective January 2025 – December 2025.

2025 additional pricing, terms and conditions

Vaccine Availability and Pricing:

- If elected by the Participating Group in the PDD, CVS Caremark shall provide vaccine administration services in accordance with such elections. Vaccines administered by Participating Pharmacies shall be adjudicated using the same AWP discount and dispensing fee as would a standard 30-day supply Brand Drug Claim plus a $20 administration fee. This administration fee can adjust seasonally (usually in August or September of each year), and CVS Caremark shall provide Participating Group written notification of such change prior to the effective date of the change and Participating Group shall have fifteen (15) days from receipt of such notification to make any changes in its vaccine program elections, including terminating its participation in the vaccine program, which changes, if any, shall be made by written notification to CVS Caremark. If Participating Group does not elect to change its vaccine program elections, the charges in CVS Caremark's notification to Participating Group shall apply to any vaccinations administered to Plan Participants on and after the effective date set forth in CVS Caremark's notification. Caremark Retail-90, CVS-90, Maintenance Choice and other 90-day network pricing terms, if any, do not apply to vaccines. Participating Group may, upon at least thirty (30) days' prior written notice to CVS Caremark, terminate participation in the vaccine program at any time.
- Vaccine Program Management fee of $0.05 per member per month.

Rebates:

- Participating Group will receive the aggregate value of the rebates quoted herein. Rebate guarantees are conditioned upon alignment with CVS Caremark Formulary – Standard Control Choice, where applicable, alignment with CVS Caremark Advanced Control Choice Formulary, where applicable, alignment with CVS Caremark Formulary – Basic Control, where applicable, alignment with CVS Caremark Formulary – Standard Formulary Opt Out, where applicable, alignment with CVS Caremark Advanced Control Specialty Formulary™, where applicable, and the Claims utilization mix and volume available at the time of pricing negotiations remaining consistent through the Term of the Agreement.
- Rebate guarantees are contingent upon CVS Caremark's ability to collect Rebates from pharmaceutical companies not being materially adversely impacted by legislative, regulatory, or judicial action, and continued full pharmaceutical company participation. In the event these conditions are not met, CVS Caremark reserves the right to equitably adjust the Rebate guarantees.
- Additional 340B exclusions may be identified and true-up may occur, after Rebates are paid. Rebate guarantees are paid quarterly for each channel.
- Specialty Rebates will not be paid in instances which Administrator's Participating Group does not have a Specialty Pharmacy Benefit.

Rebate Timing: Rebates are sent from CVS Caremark to us on a quarterly basis and are credited to the Participating Group's administrative fees. Q1 will pay in Q3, Q2 will pay in Q4, Q3 will pay in Q1, Q4 will pay in Q2. Please note this payment timing is guidance only and actual timing will depend upon CVS Caremark's timeliness and our review of rebating reporting.

Rebate Exclusions: 340B Claims and any other Claim identified as having received 340B program pricing, Compound drug Claims, Paper or Member submitted Claims, Coordination of Benefits (COB) or secondary payor Claims, Limited distribution and exclusive distribution drugs, Vaccine (including COVID) and vaccine administration claims, COVID treatment claims, Biosimilar Claims (applicable only to groups aligned to CVS Caremark Formulary – Standard Formulary Opt-Out), Over the Counter (OTC) product Claims, and Claims approved by formulary exception are also excluded from rebates. Specialty Rebates will not be paid in instances which HMA's Participating Group does not have a Specialty Pharmacy Benefit.

*** Please Note:**

- Please see Participating Group Agreement and supplemental documents for full Terms and Conditions

PRIME THERAPEUTICS® | MagellanRx MANAGEMENT℠

Pharmacy Benefits

A Forward Look at Healthcare

Known as clinical influencers who are shaping the future of pharmacy, with expertise in specialty drug management and behavioral health, Magellan Rx is a veteran in the self-funded market. With a membership of approximately 1.9 commercial PBM lives and a client base of more than 200 TPAs and 30 tribes, Magellan Rx takes a personalized and holistic approach to care by integrating physical, behavioral, and medical care.

Magellan Rx and our shared focus on low net cost and high quality of care make this relationship unique, with potential for controlling costs for customers and helping members to achieve the healthiest outcomes possible.

Highly competitive discounts and rebates ensure our clients will receive some of the most favorable rates on the market. Just 100 minimum enrolled employees to receive rate guarantees, "lowest of" pricing, no fees for claims history files, and reporting on both financial and clinical savings work to keep costs low over the plan year and identify opportunities to optimize benefit design.

Rates as follows are for Sponsors on our contract and are effective January 2025 – December 2025.*

Retail Pharmacy Network Discount Rates	
1-83 Day Supply Component	**Rate**
Minimum Brand Effective (AWP Discount) Guarantee	AWP minus 20.50%
Minimum Generic Effective Rate (AWP Discount) Guarantee	AWP minus 86.25%
Maximum Brand Claim Dispensing Fee Guarantee	$0.70
Maximum Generic Claim Dispensing Fee	$0.70
83+ Day Supply Component	**Rate**
Minimum Brand Effective (AWP Discount) Guarantee	AWP minus 22.50%
Minimum Generic Effective Rate (AWP Discount) Guarantee	AWP minus 87.25%
Maximum Brand Claim Dispensing Fee Guarantee	$0.00
Maximum Generic Claim Dispensing Fee	$0.00
Mail Order Pharmacy Discount Rates	
84+ Day Supply Component	**Rate**
Minimum Brand Effective (AWP Discount) Guarantee	AWP minus 20.50%
Minimum Generic Effective Rate (AWP Discount) Guarantee	AWP minus 86.25%
Maximum Brand Claim Dispensing Fee Guarantee	$0.70
Maximum Generic Claim Dispensing Fee	$0.70
Specialty Drugs Discount Rates for Covered drugs dispensed through the Specialty Pharmacy and the Mail Order Pharmacy (This section does not apply to claims funded thru the Specialty Select Savings Program.)	
Description	**Price**
New Specialty on the Market	12/% AWP for 30 day supply until MRx establishes a default price
Minimum Specialty Drug Effective Rate (AWP Discount) Guarantee	AWP minus 20.50%
Maximum Specialty Drug Dispensing Fee Guarantee	$0.00
Limited Distribution Drugs (LDD) dispensed from a pharmacy other than an MRx Affiliate	Excluded

***Please Note:**

- Other fees, terms and conditions apply – please see the Add'l Fees, Pricing, Terms & Condition section.
- Full terms and conditions will be available for review by client, in internal and PBM contractual documents, at time of signature
- Standard implementation requires a minimum of 90 days prior written notice. Specialty Select Savings Program may require additional lead time.

Pharmacy Benefits

Rebates as follows are for Sponsors on our contract and are effective January 2025 – December 2025.*

Accord Formulary Rebates	
Description	**Price**
Retail 30 Pharmacy	$313.20
Retail 90 Pharmacy	$659.51
Mail Order Pharmacy	$848.44
Specialty Drugs*	$3,815.72
NetResults Formulary Rebates	
Description	**Price**
Retail 30 Pharmacy	$339.75
Retail 90 Pharmacy	$749.38
Mail Order Pharmacy	$936.17
Specialty Drugs**	$4,117.53

**Specialty Drugs: Guaranteed Rebates do not apply for biosimilars, but MRx will pass through 90% of any rebates received from biosimilars.

2025 Additional Fees, Pricing, Terms & Conditions*

Administrative Fees- Paid Claim	
Description	**Fee**
Non In House Pharmacy	$0.00 Per Paid Claim
In House Pharmacy 15% or less Processing	$1.95 Per Paid Claim for 15% or less processing in house
In House Pharmacy 15% - 25% Processing	$2.95 Per Paid Claim for 15% - 25% processing in house
In House Pharmacy 25% or more Processing	$3.95 Per Paid Claim for 25% or more processing in house

***Please Note:**

- Other fees, terms and conditions apply – please see the Add'l Fees, Pricing, Terms & Condition section.
- Full terms and conditions will be available for review by client, in internal and PBM contractual documents, at time of signature.
- Standard implementation requires a minimum of 90 days prior written notice. Specialty Select Savings Program may require additional lead time.

Pharmacy Benefits

Additional fees, pricing, terms and Conditions as follows are for Sponsors on our contract and are effective January 2025 – December 2025.

Administrative Fees (Value Added)	
Service Description	**Fee**
Manual Eligibility	$2.20 per Eligibility Record
Electronic Prescribing	$0.16 per positive eligibility transaction
Retroactive Termination Letters	Quoted Upon Request
Member Packets (mailed directly to Member)	$1.25 per Member address + Postage
ID Cards	$0.25 per card (Rx Only)
Customized Materials (Member packets or other communications)	Quoted Upon Request
Member Mailings	$1.25 per letter + Postage
Direct Member Reimbursement (Member submitted manual/paper Claims)	$1.50 per Claim + Postage and Core Administrative Fee
MRx Standard Prior Authorization Program	$40.00 per review
Appeals	$150.00 per review
Independent Review Organization (IRO)	Pass Through fees from IRO entity
Processing Subrogation Claims	$3.00 per Subrogation Claim
Custom ad hoc reporting	$195.00 per hour
RDS Support Services	Quoted Upon Request
Custom FWA Program	Quoted Upon Request
Sponsor Requested audits of pharmacy	On Site Audit: $1,500.00 per audit Desk Audit: $500.00 per audit
Physician charges relating to UM activities	Pass through of physician charges

1. For the Generic Effective Rate Guarantees, both Single Source Generics and Multisource Generics are included in the calculation. "Single Source Generic" means a drug that is manufactured by and available from only one generic pharmaceutical manufacturer. "Multisource Generic" means a drug is manufactured by and available from more than one generic pharmaceutical manufacturer.

Claims for compound drugs, Specialty Drugs (except in connection with a Specialty Drug guarantee, as applicable), over-the-counter drugs, Claims with ancillary charges (but not taxes), Member-submitted Claims received after reconciliation is completed, Subrogation Claims, out-of-network Claims, Claims for Specialty Drugs funded through the MRx Select Savings Program, Claims for products used in the detection, prevention, or treatment of COVID-19, Claims for products subject to an Emergency Use Authorization (EUA), and Claims from in-house pharmacies (unless such pharmacy is in the MRx network) are excluded from the calculations. Value Max Claims are excluded from the calculation of Dispensing Fee Guarantees. Under the Retail Pharmacy guarantees, Claims from LTC Pharmacies, Home Infusion Pharmacies, and Indian/Tribal/Urban Pharmacies are excluded from the calculations, and there are no guarantees applicable to individual pharmacies. A Mail Order Pharmacy Claim for less than an 84 days' supply will be included in the Retail Pharmacy guarantee calculations. For Sponsors with fewer than 750 members, Guarantees will be reconciled and applicable at our book of business level and will be measured and reconciled at the end of our book of business Contract Year and MagellanRx may offset any surplus on any Effective Rate, Dispensing Fee Guarantee, or Rebates against a shortfall in any other such guarantee. For Sponsors with 750 or more active Members, Guarantees will be reconciled and applicable at the Sponsor level and will be measured and reconciled at the end of each applicable Sponsor's Contract Year and MagellanRx may offset any surplus on any Effective Rate or Dispensing Fee Guarantee within a dispensing channel (i.e., Retail Pharmacy, Mail Order Pharmacy, Specialty Drugs) against a shortfall in any other guarantee within the same dispensing channel. (continues on next page)

Pharmacy Benefits

Additional fees, pricing, terms and Conditions as follows are for Sponsors on our contract and are effective January 2025 – December 2025.

2. Sponsor will pay MagellanRx for each Covered Pharmaceutical dispensed to a Member through a Retail Pharmacy an amount equal to (a) the lowest of (i) AWP minus a discount plus a Dispensing Fee, (ii) submitted cost; (iii) MAC plus Dispensing Fee, or (iv) U&C, less (b) the Cost Share. These terms also apply to Member-submitted claims. Sponsor will pay for Compound Prescriptions on a separate ingredient cost and Dispensing Fee basis. Retail Pharmacy Claims may not exceed a 35-day supply except at pharmacies contracted for extended days' supply.

3. MagellanRx may add new Specialty Drugs to the Specialty Drug List as they become available in the market at a default price of AWP – 12.00% for a 30-day supply until MagellanRx establishes an appropriate contract price. If a Sponsor is enrolled in the MagellanRx Select Savings Program, guarantees for Discount Rates, Rebates, and Dispensing Fees do not apply, and MagellanRx will pay to Sponsor seventy percent (70%) of Rebates received by MagellanRx for Specialty drugs within one hundred and eighty (180) days following the end of each Contract Quarter. Limited distribution drugs dispensed from a pharmacy other than an MagellanRx Affiliate are excluded from the Specialty Drug guarantees.

4. MagellanRx (MRx) will pay (credit) to us the Guaranteed Rebates within ninety (90) days following the end of each of our Contract Quarter with MagellanRx, and we shall distribute to each Sponsor any Rebates received unless other terms have been agreed upon in writing between us and Sponsor. Guaranteed rebates do not apply for biosimilars, but MagellanRx will pass through 90% of any Rebates received for biosimilars.

Guaranteed Rebates do not include Claims for compound drugs, Claims for products for which a prescription is not required under Law, medical Claims, Claims for Limited Distribution Drugs; Claims for biosimilars, 350B Claims, non-diabetic OTC Claims, Claims for vaccines, Claims from entities eligible for federal supply schedule prices (e.g., Department of Veteran Affairs, Department of Defense, Indian Health Service), Claims for Authorized Brand Alternatives and Authorized Generics; Claims for products used in the detection, prevention, or treatment of COVID-19; Claims for drugs subject to an Emergency Use Authorization (EUA); and Ineligible Claims.

MRx will pay Rebates to us on Specialty Drug Claims subject to this Section; provided, however, that if a pharmaceutical manufacturer or aggregator seeks recoupment for a Rebate MRx received and paid to us on behalf of a Sponsor for a Specialty Drug based on such Sponsor's enrollment in an alternative funding program, then MRx will offset the amount of such Rebates, or Client will reimburse MRx the full amount of any such Rebates, as applicable, promptly upon MRx's request. For any Sponsors that have terminated under this Agreement, MRx will seek reimbursement of the full amount of any such Rebates directly from Sponsor and Sponsor agrees to reimburse MRx the full amount of any such Rebates promptly upon MRx's request.

Sponsor acknowledges that MRx will pay Rebates to us on Specialty Drug Claims on Sponsor's behalf pursuant to their Agreement; provided, however, that if a pharmaceutical manufacturer or aggregator seeks recoupment for a Rebate MRx received and paid to us on behalf of Sponsor for a Specialty Drug based on Sponsor's enrollment in an alternative funding program, then MRx will offset the amount of such Rebates against future Rebates earned by Sponsor, or Sponsor will reimburse MRx the full amount of any such Rebates, as applicable, promptly upon MRx's request. This provision shall survive termination of this Sponsor's TPA Agreement with us.

(continues on next page)

Additional fees, pricing, terms and Conditions as follows are for Sponsors on our contract and are effective January 2025 – December 2025.

4. (Continued)

MRx may contract with and/or utilize the services of a rebate aggregator to contract with and collect rebates from pharmaceutical manufacturers. The aggregator may retain a portion of the rebates and earn administrative fees for its services.

In addition to Rebates, MRx may earn additional amounts from pharmaceutical manufacturers and/or others. For example, MRx may earn administrative and/or service fees relating to administration of the Rebate program, and fees for other services rendered by MRx to such manufacturers unrelated to the administration of rebates, such as adherence and compliance programs, other patient support and similar services. MRx Affiliates may also receive purchase discounts relating to purchases of drugs for dispensing from the Mail Order Pharmacy or Specialty Pharmacy. The amounts described in this paragraph are not "Rebates" under this Agreement.

All pricing in this document is available to our new clients that become Sponsor Groups on and after the effective date of this document and to existing Sponsors on the effective date.

If a Sponsor terminates either their PBM contract thru us or terminates with us altogether, and has passed runout, the Sponsor will be responsible for paying directly to MagellanRx any Medicare or Medicaid claims that are billed up to three (3) years after date of service.

The pricing terms in this Agreement are based in part upon the Benefit Design (including but not limited to the Formulary), and other information provided by Sponsors or us to MRx during the proposal process. If a Sponsor makes any changes to the Benefit Design, makes other changes to its Plan(s), or if five percent (5%) of Claims are incurred collectively in Massachusetts, Hawaii, Alaska, Georgia, and Puerto Rico, or other changes occur, that constitute a material departure from MRx's underwriting assumptions, including any relating to the mix of 350B Claims or those based on information provided by Sponsors or us, the Parties agree to modify the terms of this pricing as of the effective date of such event/change to return MRx to its relative economic position prior to such event/change.

In the event Sponsor terminates Administrative Services Agreement with us, we may use pharmacy rebates as a set-off against amounts due to us from Sponsor or may delay remittance of these rebates to allow for final adjustments.

Sponsor acknowledges that MagellanRx provides an administrative credit to us in compensation for the services provided including enrollment processing, invoice processing and customer service among other duties. We have credited the Medical Administration fee under this acknowledgement. We have also has considered the receipt of this administrative allowance in the calculation of the Plan's TPA fees.

In the event a change in Law (including any interpretation of same) occurring after this Agreement has been signed materially impacts MRx's costs of providing any of the PBM Services hereunder, or if an action by a pharmaceutical manufacturer, any unscheduled patent expiration/availability of over-the-counter products, a drug withdrawal or recall, or industry-wide market change constitutes a material departure from MRx's underwriting assumptions, the Parties will make an equitable modification to the pricing terms of this Schedule B as of the effective date of such event/change. In the event of any increase in postage or carrier rates announced after this Agreement is signed, MRx will amend the Dispensing Fee relating to the Mail Order Pharmacy or Specialty Pharmacy, as applicable, to reflect such increased amount.

prescryptive Pharmacy Benefits

Empowering Members, Cutting Costs and Inspiring Better Health
Prescryptive Health is transforming the prescription drug market to empower consumers, cut costs, and inspire better health for employers, employees and their families. Their prescription intelligence platform provides pharmacy-direct pricing with plan design and formulary optimization to meet employers' objectives. The platform also creates rich analytics and insights into plan performance, and a one-of-a-kind consumer mobile experience that simplifies benefit utilization and drives savings. Prescryptive provides a differentiated solution to clients, bringing innovation to the plan management of pharmacy benefits integrated with our member experience.

Rates as follows are for clients on our contract and are effective January 2025-December 2025*

PBM Administrative Fees	
Description	Fee
Administrative Fee	$7.70 PMPM
Our PBM Coordination Fee	Included in Administrative Fee
Member ID Cards	Included in Administrative Fee
Paper Claim Fee	Included in Administrative Fee
Standard Reporting Member Website	Included in Administrative Fee
Member Communications	Included in Administrative Fee
Formulary Administration	Included in Administrative Fee
Rebate Administration	Included in Administrative Fee
Rebate Reporting	Included in Administrative Fee
Prior Authorization	Included in Administrative Fee
Utilization Management	Included in Administrative Fee

Retail Pharmacy	
Description	Rate
Brand Discount 30 Day Supply Discount	AWP- 19.5%
Brand Discount 90 Day Supply Discount	AWP- 22.00%
Generic Discount 30 Day Supply Discount	AWP- 86.00%
Generic Discount 90 Day Supply Discount	AWP- 93.00%

Mail Order Pharmacy	
Description	Rate
Brand Discount	AWP- 22.00%
Generic Discount	AWP- 93.00%

Specialty Pharmacy	
Description	Rate
Specialty Pharmacy[1]	AWP- 22.00%

Rebates by Brand Claim [2]	
Description	Amount
Retail 30 Day Supply	$175.00
Retail 90 Day Supply	$500.00
Mail Order 90 Day Supply	$500.00
Specialty 30 Day Supply	$1,700.00

On-Site Flu Clinics	
Retail 30 Day Supply	$175.00

prescryptive™

Pharmacy Benefits

The Prescryptive Difference:

- An engaging mobile experience integrated in real-time with benefit plans and healthcare providers, empowering consumers with information and choice
- A subscription-based flat fee that includes prior authorizations, clinical services, etc.
- 100% pass-through pricing on prescriptions and rebates
- Flexible plan: a formulary and pharmacy network design tailored to meet plan sponsors' needs and objectives
- Rich analytics and insightful data about plan performance, cost savings and employee health trends

Special Considerations:

Reimbursement Rates: Reimbursement rates quoted are average effective pharmacy network rates including dispensing fees, before rebates.
Prescryptive bills actual pharmacy reimbursement rate paid to pharmacy without spread.

Additional Fees for Service:

- Client-requested audits must be paid for by the Client.
- Other fees may apply for data integration or reporting to third parties.

In the event Client terminates Administrative Services Agreement with us, we may use pharmacy rebates as a set-off against amounts due to us from Client or may delay remittance of these rebates to allow for final adjustments.

Client acknowledges that Prescryptive Health provides an administrative credit to us in compensation for the services provided including enrollment processing, invoice processing, and customer service among other duties.

(f). Payment of Rebates to us. Upon receipt of Rebates from a Pharmaceutical Manufacturer, Prescryptive will generate a report that: (1) identifies each claim that received a Rebate and the corresponding amount of such Rebate; and (2) calculates the total Rebates due to us, on behalf of Participating Group(s) from each Pharmaceutical Manufacturer. Prescryptive shall provide such Rebate Report and pay to us one hundred percent (100%) of the total Rebates due to Participating Groups within fifteen (15) business days of the end of the month in which Prescryptive received payment by the Pharmaceutical Manufacturer. Prescryptive shall not have any liability to us, Participating Groups or Members for any failure by any Pharmaceutical Manufacturer to pay any Rebates, any breach of a Rebate contract by any Pharmaceutical Manufacturer, or any negligence or willful misconduct by any Pharmaceutical Manufacturer.

"Adequate Network" shall mean Prescryptive's list of Participating Pharmacies for which 90% of Members who reside in urban areas are within 3 miles of a Participating Pharmacy; 90% of Members who reside in suburban areas are within 5 miles of a Participating Pharmacy; and 70% of Members who reside in rural areas are within 25 miles of a Participating Pharmacy.

All pricing in this document is available to our new clients that become Client Groups on and after the effective date of this document and to existing Sponsors on the effective date.

If a Client terminates either their PBM contract thru us or terminates with us altogether, and has passed runout, the Client will be responsible for paying directly to Prescryptive any Medicare or Medicaid claims that are billed up to three (3) years after date of service.

Footnotes:

[1] Excludes Limited Distribution Drugs which vary by individual medication.

[2] Rebate amounts are the property of the plan sponsor and 100% are paid to the plan sponsor to reduce drug costs.

Disclosures

Please Note: the content in this and the accompanying Client Insights document is intended to be informational only and cannot be relied upon as legal advice. The Plan Sponsor is ultimately responsible for the compliance of the Plan design and the benefits offered.

Service	Description of Disclosures
Medical Administration	All our Administration Fees are NET of broker commission. Run-out Processing is subject to 3 months of base administrative fee charged by line of coverage. Any changes to the Plan's benefit design and/or Plan Administration must be communicated by the Plan Sponsor to us a minimum of sixty (60) days prior to renewal. We reserve the right to pass through any and all regulatory assessments, fees, or similar financial obligations that are attributable to a client health plan whether known or not during the sales process or that may become applicable during the term of our services to a client and its health plan. We shall use reasonable efforts to identify and communicate to clients about assessments that it will be liable for, but shall bear no liability for such obligations. We reserve the right to re-rate services based on the complexity of the Plan's benefit design, and in the event Plan enrollment deviates +/- 10% from the covered lives at the point renewal was issued.
Pharmacy Benefit Manager (PBM)	We are integrated with three Preferred PBMs and work closely with their teams to manage client and member satisfaction as well reporting and rebate distribution (as applicable). Clients selecting one our three preferred PBMs must sign a participating group/sponsor agreement with the PBM to agreeing to fund claims. We require at least 100 day's prior written notice prior to the end of your then current initial or renewal term. A run-out terms agreement will be required to terminate a preferred PBM agreement. Termination for convenience outside of the end current term is not allowed. As part of our arrangements with our preferred CVS and MagellanRx PBMs, we receive compensation on certain claims processed under the client's Rx benefits. Clients selecting our CVS or MagellanRx PBM contract qualify for an administrative credit. On our CVS Caremark contract there is a discount of $2.00 PEPM, on our MagellanRx contract there is a discount of $2.00 or $3,00 PEPM, as determined by the contract, we apply credits to the base medical administration fees. For clients selecting our preferred Prescryptive contract, we receive compensation in the form of a partial retention of the PEPM fee. Additional approved PBM's where we accommodate eligibility and accumulator file feeds only, include Costco Health Solutions, Navitus Health Solutions, Express Scripts, MaxorPlus, Elixir Pharmacy, RxBenefits, NW Pharmacy Services, OptumRx, WellDyneRx, SAV-RX and SmithRx. We reserve the right to charge set up fees associated with a new approved PBM.
Non-PBM Buy up products	Most of our buy-up products will require accompanying SPD language updates that our team will provide as an amendment. Clients opting into our non-PBM buy-up products agree to provide at least 60 day's termination notice for each product should client choose to terminate on not renew elected buy-up products. For products with claims-based billing, runout terms apply. Mid-term termination for convenience may be prohibited on select products.

Disclosures

Please Note: the content in this and the accompanying Client Insights document is intended to be informational only and cannot be relied upon as legal advice. The Plan Sponsor is ultimately responsible for the compliance of the Plan design and the benefits offered.

Product/ Service	Description of Disclosures
SPD, SBC, and Plan Amendment Drafting Support	We shall support the initial creation of your SBC, your SPD, and assist in preparation of Plan amendments. In accordance with applicable federal and/or state requirements, the Plan Sponsor must ensure timely approval and distribution of plan documents to Plan Participants. We require a signed copy of the SPD provided by the Plan Sponsor no later than one-hundred twenty (120) days after the start of the Plan Year. For an additional fee, Plan Sponsor may request that we support fulfillment and mailing of SPDs.
Data Integration with Third Party Vendors (Not Our Contracted Partners)	We shall evaluate requests for the release of health plan data to third-party vendors with whom the client has engaged directly. If the request is approved, client and its vendor may be required to sign additional data protection agreements. We reserve the right to charge a data integration fee for supporting the release of data to third parties.
Actuarial and Compliance Services – Washington state-based employers with Washington 1065	The federal No Surprises Act protects your members from surprise billing for emergency services. Plan Sponsors who wish to offer further protections for members under the Washington state surprise billing law must opt-in directly with Washington Office of the Insurance Commissioner and notify their account manager a minimum of thirty (30) days prior to your effective date. We do not provide support for any regulatory or compliance filings that are not listed in this renewal document. The Plan Sponsor is responsible for 1) completing any filings the Plan is required to file with state or federal agencies, 2) providing mandated notices to plan participants (such as the Plan's Notice of Privacy Practices and Summary of Material Modifications).
Stop Loss	We require that client's partner with one of our Preferred stop loss Carriers SunLife Financial, HM Insurance Group, QBE Insurance Corporation, Symetra Financial, Tokio Marine HCC, Physicians Insurance, Commencement Bay Risk Managers, SwissRe, Voya Financial, ISU w/Companion, Berkshire Hathaway, Medical Risk Managers (MRM), Starline and iiSi. If we agree to work with a non-preferred stop loss carrier, we will charge an Interface Fee of $3.50 PEPM. We reserve the right decline to work with non-preferred stop loss carriers at our discretion.

Disclosures

Please Note: the content in this and the accompanying Client Insights document is intended to be informational only and cannot be relied upon as legal advice. The Plan Sponsor is ultimately responsible for the compliance of the Plan design and the benefits offered.

Product/Service	Description of Disclosures
Payment Integrity Program	We retain the following shared savings fees on our Payment Integrity Program: 30% of savings – Medical bill audit and claim review, out-of-network claim re-pricing services, claims negotiation and medication and condition steerage programs. 30% of savings – Electronic review of claims for code edits prior to payment. Data Mining and Overpayment Recovery 15% for current claims and 17% for aged claims retained by Cotiviti on all recoveries. On post-payment COB and Code Edit recoveries identified by Cotiviti, we retain an additional 13-15%. Subrogation services The plan will receive 73% of recovered funds. Of the remaining, 22% is retained by The Phia Group, and 5% is retained by HMA.* *In the event of litigation to enforce the Plan's right of recovery, The Phia Group fee will increase to 33.3% and HMA shall not retain any compensation. 9.5% of recovered funds – credit balance premier health services partner on site with providers across the country. 30% of savings – fraud, waste, and abuse • 17.5% of savings retained by Optum • 12.5% administrative allowance
HRIS Vendor Changes	HRIS vendor change requests within 3 years of initial set-up incur a charge of $5,000

HMA 2025 Renewal _12.26.24_rev2.SD

Final Audit Report 2025-02-21

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