ADMINISTRATIVE SERVICES AGREEMENT

This Administrative Services Agreement ("Agreement") is entered into by and between City of Littleton ("Employer") and Rocky Mountain Hospital and Medical Service, Inc. dba Anthem Blue Cross and Blue Shield ("Anthem") and is effective as of January 1, 2026 upon the following terms and conditions:

1. Employer is the sponsor of a self-funded Group Health Plan (as defined below) providing, among other things, health care benefits to certain eligible employees and their qualified dependents.

2. Employer desires to retain Anthem as an independent contractor to administer certain elements of Employer's Group Health Plan.

3. Anthem desires to administer certain elements of Employer's Group Health Plan pursuant to the terms of this Agreement.

In consideration of the promises and the mutual covenants contained in this Agreement, Anthem and Employer (the "Party" or "Parties" as appropriate) agree as follows:

ARTICLE 1 - DEFINITIONS

For purposes of this Agreement and any amendments, attachments or schedules to this Agreement, the following words and terms have the following meanings unless the context or use clearly indicates another meaning or intent:

ADMINISTRATIVE SERVICES FEES. The amount payable to Anthem in consideration of its administrative services and operating expenses as indicated in Section 3 of Schedule A, excluding any cost for stop loss insurance coverage or any other policy of insurance, if applicable. All additional charges not included in the Administrative Services Fees are specified elsewhere in this Agreement.

AGREEMENT PERIOD. The period of time indicated in Section 1 of Schedule A.

ANTHEM AFFILIATE. An entity controlling, under common control with or controlled by Anthem.

BENEFITS BOOKLET. A description of the portion of the health care benefits provided under the Plan that is administered by Anthem.

BILLED CHARGES. The amount that appears on a Member's Claim form (or other written notification acceptable to Anthem that Covered Services have been provided) as the Provider's charge for the services rendered to a Member, without any adjustment or reduction and irrespective of any applicable reimbursement arrangement with the Provider.

BLUE CROSS BLUE SHIELD ASSOCIATION ("BCBSA"). An association of independent Blue Cross and Blue Shield companies.

CLAIM. Written or electronic notice of a request for reimbursement of any health care service or supply on a form acceptable to Anthem.

CLAIMS RUNOUT SERVICES. Processing, including adjustments, and payment of Claims that are incurred but unreported and/or unpaid as of the date this Agreement terminates.

CONSOLIDATED APPROPRIATIONS ACT ("CAA"). The Consolidated Appropriations Act of 2021 (42 USC 300gg, et seq. and 29 USC 1185, et seq.), as amended, and regulations promulgated thereunder.

COVERED SERVICE. Any health care service or supply rendered to Members for which benefits are eligible for reimbursement pursuant to the terms of the applicable Benefits Booklet.

EMPLOYER AFFILIATES. Companies affiliated with Employer that are participating in the Plan and which, along with the Employer constitute a single "control group" as that term is used in the Internal Revenue Code.

GROUP HEALTH PLAN OR PLAN. An employee welfare benefit plan established by the Employer, in effect as of the Effective Date, as described in the Plan Documents, as they may be amended from time to time.

INTER-PLAN ARRANGEMENTS. Blue Cross and Blue Shield Association programs, including the BlueCard Program, where Anthem can process certain Claims for Covered Services received by Members, which may include accessing the reimbursement arrangement of a Provider that has contracted with another Blue Cross and/or Blue Shield plan.

INVOICE DUE DATE. The date on the invoice provided to Employer indicating when payment is due or as otherwise agreed to by the Parties.

MEMBER. The individuals, including the Subscriber and his/her dependents, as defined in the Benefits Booklet, who have satisfied the Plan eligibility requirements of Employer, applied for coverage, and been enrolled for Plan benefits.

NETWORK PROVIDER. A physician, health professional, hospital, pharmacy, or other individual, organization and/or facility that has entered into a contract, either directly or indirectly, with Anthem to provide Covered Services to Members through negotiated reimbursement arrangements.

PAID CLAIM. The amount charged to Employer for Covered Services provided during the term of this Agreement and any Claims Runout Period. Paid Claims may also include any applicable surcharges assessed by a state or government agency and any applicable interest paid. In addition, Paid Claims shall be determined as follows:

1. Provider and Vendor Claims. Except as otherwise provided in this Agreement, Paid Claims shall mean the amount Anthem actually pays the Provider or Vendor without regard to: (i) whether Anthem reimburses such Provider or Vendor on a percentage of charges basis, a fixed payment basis, a global fee basis, single case rate, or other reimbursement methodology; (ii) whether such amount is more or less than the Provider's or Vendor's actual Billed Charges for a particular service or supply; or (iii) whether such payments are increased or decreased by the Provider's or Vendor's achievement of, or failure to achieve, certain specified goals, outcomes or standards adopted by Anthem.

2. This provision is intentionally removed.

3. Payment Innovation Programs. If a Provider or Vendor participates in any Anthem payment innovation program, excluding any programs described in paragraph 1 of this provision, in which performance incentives, rewards or bonuses are paid based on the achievement of cost, quality, efficiency, or service standards or metrics adopted by Anthem or in which fees are paid to Providers or Vendors for managing and/or coordinating the care or cost of care for designated Members ("Payment Innovation Programs"), Paid Claims shall also include the amount of such payments to Providers or Vendors for these Payment Innovation Programs. Such payments may be charged to Employer on a per Claim, lump sum, per Subscriber, or per Member basis and shall be based on Anthem's predetermined methodology for such Payment Innovation Program, as may be amended from time to time. The total monies charged in advance to fund a Payment Innovation Program shall be actuarially determined as the amount necessary to fund the expected payments attributable to the Payment Innovation Program. Prior to its implementation, Anthem shall provide Employer with a description of the Payment Innovation Program, the methodology that will be utilized to charge the Employer, and any reconciliation process performed in connection with such program. Payments to Providers or Vendors under these Payment Innovation Programs shall not impact Member cost shares.

4. This provision is intentionally omitted.

5. Claims Payment Pursuant to any Judgment, Settlement, Legal or Administrative Proceeding. Subject to Article 16 as applicable, Paid Claims shall include any Claim amount paid as the result of a settlement, judgment, or legal, regulatory or administrative proceeding brought against the Plan and/or Anthem, or otherwise agreed to by Anthem, with respect to the decisions made by Anthem regarding the coverage of or amounts paid for services under the terms of the Plan. Paid Claims also includes any amount paid as a result of dispute resolution procedures.

6. Claims Payment Pursuant To Inter-Plan Arrangements And Other BCBSA Programs. Paid Claims shall include any amount paid for Covered Services that are processed through Inter-Plan Arrangements or for any amounts paid for Covered Services provided through another BCBSA program (e.g., BCBSA Blue Distinction Centers for Transplant). More information about Inter-Plan Arrangements is found in the Inter-Plan Arrangements Schedule of this Agreement.

7. Claims Payment Pursuant To A Consumer Directed Health Plan Account. If applicable to Plan benefits and as indicated on Schedule A or B of this Agreement, Paid Claims shall include any amount actually paid by Anthem from a consumer directed health plan account, such as a health reimbursement account or a health incentive account.

PLAN DOCUMENTS. The documents that set forth the terms of the Plan, and which include the Benefits Booklet.

PROPRIETARY INFORMATION AND CONFIDENTIAL INFORMATION. Employer's Proprietary Information is information about the systems, procedures, methodologies and practices used by Employer to run its operations and the Plan and other non-public information about Employer. Anthem's Proprietary Information is non-public, trade secret, commercially valuable, or competitively sensitive information, or other material and information relating to the products, business, or activities of Anthem or an Anthem Affiliate, including but not limited to: (1) information about Anthem's Provider networks, Provider negotiated fees, Provider discounts, and Provider contract terms; (2) information about the systems, procedures, methodologies, and practices used by Anthem and Anthem Affiliates in performing their services such as underwriting, Claims processing, Claims payment, and health care management activities; and (3) combinations of data elements that could enable information of this kind to be derived or calculated. Anthem's Confidential Information is information that Anthem or an Anthem Affiliate is obligated by law or contract to protect, including but not limited to: (1) Social Security Numbers; (2) Provider Tax Identification Numbers; (3) National Provider Identification Numbers; (4) Provider names, Provider addresses, and other identifying information about Providers; and (5) Drug Enforcement Administration Numbers, pharmacy numbers, and other identifying information about pharmacies.

PROVIDER. A duly licensed physician, health professional, hospital, pharmacy or other individual, organization and/or facility that provides health services or supplies within the scope of an applicable license and/or certification and meets any other requirements set forth in the Benefits Booklet.

SUBSCRIBER. An employee or retiree of Employer or other eligible person (other than a dependent) who is enrolled in the Plan.

VENDOR. A person or entity other than a Provider, including an Anthem Affiliate, that provides services or supplies pursuant to a contract with Anthem.

ARTICLE 2 - ADMINISTRATIVE SERVICES PROVIDED BY ANTHEM

a. Anthem shall process the enrollment of eligible individuals and termination of Members as directed by the Employer subject to the provisions of this Agreement. Anthem shall, with the assistance of Employer, respond to direct routine inquiries made to it by employees and other persons concerning eligibility in the Plan.

b. Anthem shall perform the following Claims administrative services:

    1. Process Claims with a Claims Incurred Date indicated in Section 1 of Schedule A and provide customer service, including investigating and reviewing such Claims to determine what amount, if any, is due and payable according to the terms and conditions of the Benefits Booklet and this Agreement. Anthem shall perform coordination of benefits ("COB") with other payors, including Medicare. In processing Claims, Anthem shall utilize Anthem's medical policies and medical policy exception process, its definition of medical necessity, its precertification and/or preauthorization policies, Provider contract requirements and applicable Claim timely filing limits.

    2. Disburse to the applicable individuals or entities (including Providers and Vendors) payments that it determines to be due according to the provisions of the Benefits Booklet.

    3. Provide notice in writing when a Claim for benefits has been denied which notice shall set forth the reasons for the denial and the right to a full and fair review of the denial under the terms of the Benefits Booklet and shall otherwise satisfy applicable regulatory requirements governing the notice of a denied Claim.

    4. Administration of independent dispute resolution process for non-Network Provider Claims (including non-network air ambulance Provider Claims) as set forth under the CAA or, if applicable, through state law with Employer election as required, for the fee set forth in Section 3.C of Schedule A. Employer agrees to promptly notify Anthem if an independent dispute resolution request is received. Failure to promptly notify Anthem may impact independent dispute resolution process.

c. Employer delegates to Anthem fiduciary authority to determine claims for benefits under the Plan as well as the authority to act as the appropriate fiduciary to determine appeals of any adverse benefit determinations under the Plan. Anthem shall administer complaints, appeals and requests for independent review according to Anthem's complaint and appeals policy, and any applicable law or regulation unless otherwise provided in the Benefits Booklet. In carrying out this authority, Anthem is delegated full discretion to determine eligibility for benefits under the Plan and to interpret the terms of the Plan. Anthem shall be deemed to have properly exercised such authority unless a court or other regulatory authority determines that Anthem has abused its discretion or that its decision is arbitrary and capricious. Anthem is a fiduciary of the Plan only to the extent necessary to perform its obligations and duties as expressed in this Agreement and only to the extent that its performance of such actions constitutes fiduciary action. Anthem shall charge Employer the fee described in Section 3.C of Schedule A for any independent review conducted pursuant to this provision.

d. Anthem shall have the authority, in its discretion, to institute from time to time, pilot initiatives in certain designated geographic areas. A pilot initiative may affect some, but not all Members under the Plan. These programs will not result in the payment of benefits which are not provided in the applicable Benefits Booklet, unless approved by Employer. Anthem reserves the right to discontinue a pilot initiative at any time without advance notice to Employer.

e. Anthem shall perform Claims prepayment analysis and recovery services as provided in Articles 4 and 13.

f. Anthem shall issue identification cards to Subscribers and/or Members, as applicable, and the content and design of the identification cards shall comply with CAA and BCBSA requirements.

g. Recommendations on replacement products may be offered to Members becoming Medicare eligible.

h. Consistent with the requirements of the CAA, Anthem shall provide Members and potential Members access to an online directory of Providers contracted with Anthem ("Provider Directories"). Members may also contact customer service for a listing of applicable Network Providers. Additionally, if applicable to Plan benefits, Anthem shall ensure that Members and potential Members have access to the BlueCard directory of Providers via a website sponsored by BCBSA. Anthem grants Employer the permission to link to Anthem’s website to allow Members to access Provider Directories and other available information, including information needed to comply with requirements of applicable law such as posting of machine readable files.

i. Anthem reserves the right to make benefit payments to either Providers or Members at its discretion. Employer agrees that the terms of the Plan will include provisions for supporting such discretion in determining the direction of payment including, but not limited to, a provision prohibiting Members from assigning their rights to receive benefit payments, unless otherwise prohibited by applicable law.

j. If applicable to the Plan benefits and as indicated in Schedule A or B of this Agreement, Anthem may provide or arrange for the provision of the following managed care services:

    1. Conduct medical necessity review, utilization review, and a referral process, which may include, but is not limited to: (a) preadmission review to evaluate and determine the medical necessity of an admission or procedure and the appropriate level of care, and for an inpatient admission, to authorize an initial length of stay; (b) concurrent review throughout the course of the inpatient admission for authorization of additional days of care as warranted by the patient's medical condition; (c) retrospective review; and (d) authorizing a referral to a non-Network Provider. Anthem shall have the authority to waive a requirement if, in Anthem's discretion, such exception is in the best interest of the Member or the Plan, or is in furtherance of the provision of cost effective services under this Agreement.

    2. Perform case management to identify short and long term treatment programs in cases of severe or chronic illness or injury. Anthem may, but is not required to, customize benefits in limited circumstances by approving otherwise non-Covered Services if, in the discretion of Anthem, such exception is in the best interest of the Member and the Plan.

    3. Provide access to a specialty network of Providers if the Plan includes a specialty network. Anthem reserves the right to establish specialty networks for certain specialty or referral care.

    4. Provide any other managed care services incident to or necessary for the performance of the services set forth in this Article 2.

k. If applicable to the Plan benefits and as indicated in Schedule A or B of this Agreement, Anthem shall offer programs to help Employer effectively manage the cost of care, and Employer shall pay fees for the programs selected by Employer only if such fees are indicated in Section 3(B) of Schedule A. Employer shall abide by all applicable policies and procedures of the programs selected, which may require Employer to provide requested information prior to Anthem initiating the service.

l. Unless otherwise elected by Employer, Anthem shall produce and maintain a master copy of the Benefits Booklet, using its standard template and make changes and amendments to the master copy of the Benefits Booklet. Anthem shall incorporate any approved changes or amendments pursuant to Article 18(a) and Article 18(b) of this Agreement. Employer shall determine, in its sole discretion, whether Anthem has accurately produced the Benefits Booklet and has fully implemented the approved changes or amendments. Until Employer has approved the Benefits Booklet, Anthem will administer the quoted benefits according to Anthem's most similar standard Benefits Booklet language. Notwithstanding the foregoing, if Employer elects to produce and maintain its own Benefits Booklet, Employer agrees to incorporate language that is consistent with Anthem's standard processes.

m. Anthem will provide Employer with Plan data and assistance necessary for preparation of the Plan's information returns and forms required by federal or state laws. Anthem shall prepare and mail all IRS Form 1099's and any other similar form that is given to Providers or brokers.

n. Anthem shall administer unclaimed funds associated with Paid Claims that are not processed through Inter-Plan Arrangements pursuant to unclaimed property or escheat laws and shall make any required payment and file any required reports under such laws. Inter-Plan Arrangement Paid Claims are processed according to the Host Blue's procedures and may be escheated to the state.

o. Anthem's standard policies and procedures, including electronic communication with Members and Provider contracts, as they may be amended from time to time, will be used in the provision of services specified in this Agreement. In the event of any conflict between this Agreement and any of Anthem's policies and procedures, this Agreement will govern. In the event of any conflict between this Agreement and the Provider contracts, the Provider contracts will govern the rights and obligations as between the Parties and Providers (*e.g.*, reimbursement rates and methodologies, filing and Claim adjustment time frames, and high dollar Claim review).

p. This provision is intentionally omitted.

q. Select state laws require Employers to finance health related initiatives through residency-based assessments and/or surcharges added to certain Paid Claims. After Employer completes any applicable forms, Anthem shall make all assessment and/or surcharge payments on behalf of Employer to the appropriate pools administered by the respective states, based primarily upon Anthem's Paid Claims information and Member information provided to Anthem by Employer. Examples of such assessments and surcharges include, but are not limited to, the Massachusetts Health Safety Net Trust Fund and the New York Health Care Reform Act.

r. Anthem shall provide required notices describing Member's rights under the Women's Health and Cancer Rights Act (WHCRA) upon a Member's enrollment and at least annually thereafter.

s. Anthem shall have the authority, in its sole discretion, to build and maintain its Provider network on its own behalf. In building and maintaining its Provider network, Anthem is not acting on behalf of or as an agent for any employer or member. Nothing in this Agreement shall be interpreted to require Anthem to maintain negotiated fees or reimbursement arrangements or other relationships with certain Providers or Vendors or to negotiate on behalf of or for the benefit of Employer or Employer's Members. Anthem will be solely responsible for acting as a liaison with Providers including, but not limited to, responding to Provider inquiries, negotiating contract language and negotiating rates with Providers or auditing Providers, and Employer agrees that it will be governed by the terms and conditions of these agreements.

t. If a catastrophic event (whether weather-related, caused by a natural disaster, or caused by war, terrorism, pandemic, or similar event) occurs that affects Members in one or more locations, and such catastrophic event prevents or interferes with Anthem's ability to conduct its normal business with respect to such Members or prevents or interferes with Members' ability to access their benefits, Anthem shall have the right, without first seeking consent from Employer, to take reasonable and necessary steps to process Claims and provide managed care services in a manner that may be inconsistent with the Benefits Booklet in order to minimize the effect such catastrophic event has on Members. As soon as practicable after a catastrophic event, Anthem shall report its actions to Employer. Employer shall reimburse Anthem for amounts paid in good faith under the circumstances and such amounts shall constitute Paid Claims, even if the charges incurred were not for services otherwise covered under the Benefits Booklet.

u. Anthem shall submit any claim that is required to be filed under any stop loss policy issued by Anthem or an Anthem Affiliate. Anthem shall have no obligation to prepare or file any claim for excess risk or stop loss coverage under a policy not issued by Anthem or an Anthem Affiliate. Anthem shall provide Employer with Claims data pursuant to Article 11 of this Agreement if Employer chooses to file a claim under a stop loss policy issued by an entity other than Anthem or an Anthem Affiliate. Anthem shall assume no liability or responsibility to Employer if an unaffiliated stop loss carrier determines that a stop loss claim is not covered for any reason.

v. This provision is intentionally omitted.

w. If a Member is a Massachusetts resident, Anthem shall mail the Member notices required by the Massachusetts Health Connector for Plans that are in compliance with Massachusetts minimum creditable coverage requirements on an annual basis. If a Member works in Massachusetts for Employer, but resides in another State, Anthem will provide such notices upon Member request.

x. Anthem is the responsible reporting entity ("RRE") for the Plan as that term is defined pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007. In order to fulfill its RRE obligation, Anthem requires information from the Employer, including, but not limited to, Member Social Security Numbers. Employer shall cooperate with Anthem and timely respond to any request for information made by Anthem.

y. Anthem will provide Employer with Plan information and assistance necessary for the preparation of the Plan's Summary of Benefits and Coverage ("SBC") related to the elements of the Plan that Anthem administers. Employer is solely responsible for ensuring that the SBC accurately reflects the benefits Employer will offer and for finalizing and distributing the SBC to Subscribers. Notwithstanding the provisions in Article 18(a), if Employer's open enrollment period is at a time other than 30 days prior to the end of an Agreement Period, Employer agrees to provide Anthem with any changes to the benefits Anthem administers at least 60 days prior to the start of the open enrollment period.

z. Anthem generally receives Member telephone numbers from Employer through enrollment files or the online employer access portal. Telephone numbers are provided directly to Employer by Members with the understanding that Anthem may contact them, and Employer does not obtain telephone numbers through a service or a third party. Anthem may contact Members by telephone for clinical purposes, benefit related issues or to perform services under the Agreement. Telephone numbers may be updated periodically by Members, and Anthem will honor do not call requests. With regard to Anthem's use of Member telephone numbers, Employer agrees to retain Member enrollment records for a period of at least 5 years or as otherwise set forth in the Telephone Consumer Protection Act and, upon request, will provide such records to Anthem in a timely manner.

aa. Anthem shall provide reporting as indicated in Schedule B to assist with compliance under the CAA.

ab. Anthem’s Information Security Schedule is attached hereto and is made part of this Agreement.

ac. Anthem will provide reasonable assistance to Employer in the event of a regulatory audit.

ARTICLE 3 - OBLIGATIONS OF EMPLOYER

a. Employer shall furnish to Anthem initial eligibility information regarding Members. Employer is responsible for determining eligibility of individuals and advising Anthem in a timely manner, through a method agreed upon by the Parties, as to which employees, dependents, and other individuals are to be enrolled Members. Anthem reserves the right to limit the effective date of retroactive enrollment as indicated in Schedule A. Such retroactive enrollments shall be subject to Anthem's receipt of any applicable fees as indicated in Section 3 of Schedule A. Employer shall keep such records and furnish to Anthem such notification and other information as may be required by Anthem for the purpose of enrolling Members, processing terminations, effecting COBRA coverage elections, effecting changes in single or family coverage status, effecting changes due to a Member becoming eligible or ineligible for Medicare, effecting changes due to a leave of absence, or for any other purpose reasonably related to the administration of eligibility under this Agreement. Employer acknowledges that prompt and complete furnishing of the required eligibility information is essential to the timely, accurate, and efficient processing of Claims. As part of its obligation to provide eligibility information to Anthem, Employer agrees to use best efforts at the time of enrollment to request Member email addresses and/or smart phone numbers. Consistent with 29 CFR 2520.104B-31, Anthem will provide Employer with materials to share with Members advising that providing email addresses/smart phone numbers serves as the Member's consent to receive documents digitally, explaining that Anthem will use the email address/smart phone number to provide the documents described in the Anthem materials, describing how Members may access those documents, and clarifying that Members may withdraw consent to receive documents digitally at any time. Nothing herein prohibits Employer from providing its required disclosures in a digital manner.

   Employer shall notify Anthem on at least a monthly basis of the Subscribers, dependents, or other individuals that will be or have become ineligible for benefits under the Plan. Upon receipt of such notice, Anthem shall terminate coverage in accordance with the Benefits Booklet. Employer shall give Anthem advance notice, if possible, of any Member's expected termination and/or retirement. Anthem reserves the right to limit retroactive terminations as indicated in Schedule A. Anthem shall credit Employer applicable fee for such retroactive terminations as indicated in Section 3 of Schedule A.

b. Employer has all discretionary authority and control over the management of the Plan, and all discretionary authority and responsibility for the administration of the Plan except as delegated to Anthem in Article 2(c) and Article 2(j) of this Agreement. Employer retains all final authority and responsibility for the Plan and its operation and Anthem is empowered to act on behalf of Employer in connection with the Plan only as expressly stated in this Agreement or as otherwise agreed to by the Parties in writing. Employer shall provide Anthem with timely, accurate and complete information necessary for any services administered by Anthem. Employer or its designee shall provide Anthem with timely, accurate and complete information necessary for any Anthem obligation under the Agreement.

c. It is understood and agreed that the provision of any notice, election form, or communication and the collection of any applicable premium or fees required by or associated with Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), or any other applicable law governing continuation of health care coverage, shall be the sole responsibility of Employer and not Anthem, except as otherwise agreed to in a written agreement between the Parties.

d. This provision is intentionally omitted.

e. Employer agrees to and shall collect those contributions from Subscribers that are required by Employer for participation in the Plan. If Employer elects Anthem's stop loss coverage, Employer shall abide by Anthem's participation and contribution guidelines.

f. Unless otherwise agreed to by the Parties in writing, Employer shall prepare and distribute all notices or summaries of changes or material modifications to the Plan. Employer shall ensure that if it creates any documents that refer to benefits offered under the Plan, the documents will accurately reflect the terms of the Benefits Booklet. Employer is solely responsible for determining the tax status of the Plan and for compliance with applicable tax laws, regulations, and guidance.

g. To the extent that Medicare, Medicaid, the Veterans Administration or any other federal or state agency or entity asserts a reimbursement right against Employer, the Plan, or Anthem pursuant to that agency's or entity's rights under applicable law with respect to Claims processed by Anthem under this Agreement, the Employer shall be responsible for reimbursing Anthem any such amounts determined to be owed.

h. Employer shall give notice to Anthem of the expected occurrence of any of the following events (including a description of the event), with such notice to be given at least 30 days prior to the effective date of the event, unless such advance notice is prohibited by law or contract in which case, notice will be provided as soon as practicable:

1. Change of Employer's name; or

2. The sale or other transfer of all or substantially all of the assets of either Employer or any Employer Affiliates or the sale or other transfer of the equity of Employer or any Employer Affiliates, or;

3. Any bankruptcy, receivership, insolvency or inability of Employer to pay its debts as they become due.

i. This provision is intentionally omitted.

j. The Employer may request Anthem, on an exception basis, to process and pay Claims that were denied by Anthem or take other actions with respect to the Plan that are not specifically set forth in this Agreement or the Benefits Booklet. In such cases, any payments shall not count toward the stop loss accumulators under a stop loss agreement issued by Anthem, unless otherwise agreed to by Anthem. Anthem may charge Employer a processing fee that has been mutually agreed to by the Parties prior to the processing of the Claim. Anthem shall not be responsible for any liability associated with any act or omission undertaken at the direction of, or in accordance with, instructions received from the Employer under this provision.

k. Employer acknowledges and agrees that full payment of amounts due to Anthem by the Invoice Due Date as set forth in Articles 4 and 5 of this Agreement is a condition precedent to Anthem's fulfillment of its obligations as set forth in Article 2, including but not limited to Anthem's performance of Claims administrative services set forth in Article 2(b).

ARTICLE 4 - CLAIMS PAYMENT METHOD

a. Employer shall pay or fund Paid Claims according to the Claims payment method described in Section 4 of Schedule A. Employer shall pay or fund such amounts by the Invoice Due Date. In addition, from time to time, the Parties acknowledge that Employer may request a review of the appropriateness of a Claim payment and, during the review period, Employer shall pay or fund such Claim.

b. Consistent with Article 13, the Parties acknowledge that, from time to time, a Claims adjustment may be necessary as a result of coordination of benefits, subrogation, workers' compensation, other third party recoveries, settlements with a Provider or Vendor, payment errors and the like, and that the adjustment will take the form of a debit (for an additional amount paid by Anthem) or a credit (for an amount refunded to Employer) ("Adjusted Claims"). Employer will be assessed or will receive, as applicable, a proportionate share of Paid Claims that are the result of Anthem's settlement with a Provider or Vendor. The Adjusted Claim shall be reflected as a line item on the invoice and shall be treated as an adjustment to the Claims payment made in the billing period or Claims Runout Period in which the adjustment occurs, rather than as a retroactive adjustment to the Claim in the billing period or Claims Runout Period in which it was initially reported as paid. Any Claims credit may be reduced by a fee as indicated in Schedule A of this Agreement. In addition, a credit shall not be provided to Employer for a recovery related to a Claim that was covered under stop loss coverage provided by Anthem.

c. Employer acknowledges and directs Anthem to utilize offsetting and cross-plan offsetting to recover overpaid Claims from Network Providers. Offsetting and cross-plan offsetting will be conducted only in cooperation with non-Network Providers who have expressly agreed to such procedures and have agreed that members will be held harmless. Offsetting is the practice of Anthem recovering overpayments made to a Network Provider by withholding overpaid amounts from subsequent payments to be made to the same Network Provider. Cross-plan offsetting is the practice of Anthem recovering overpayments made to a Network Provider for one member by withholding the overpaid amount from subsequent payments to be made to the same Network Provider for another member, who receives benefits under a different group health plan for which Anthem pays the Claims on behalf of a different employer.

ARTICLE 5 - ADMINISTRATIVE SERVICES FEES

During the term of this Agreement, Employer shall pay Anthem the Administrative Services Fees, described in Section 3 of Schedule A. Employer shall pay the Administrative Services Fees and other fees authorized under this Agreement by the applicable Invoice Due Date according to the payment method described in Section 5 of Schedule A.

ARTICLE 6 - RENEWAL SCHEDULES

If Anthem offers to renew this Agreement at the end of an Agreement Period, then Anthem shall provide Employer with the terms and conditions of the proposed renewal in writing within the time period provided in Section 1 of Schedule A. Employer shall notify Anthem in writing of its selection from the renewal options by indicating its selection and signing Anthem's designated renewal form.

ARTICLE 7 - CLAIMS RUNOUT SERVICES

a. Claims Runout Services shall be provided for the period of time provided in Section 6 of Schedule A (the "Claims Runout Period"), except such Claims Runout services shall not be provided in the event that termination is due to non-payment pursuant to Article 19(a) of this Agreement. During the Claims Runout Period, the terms of this Agreement shall continue to apply. Anthem shall have no obligation to process or pay any Claims or forward Claims to Employer beyond the Claims Runout Period. Any amounts recovered beyond the Claims Runout Period shall be retained by Anthem as reasonable compensation for services under this Agreement. Anthem shall, however, return any recoveries for which Anthem had received monies, but had not processed the recovery prior to the end of the Claims Runout Period. In addition, Employer shall have no obligation to reimburse Anthem for any amounts paid by Anthem due to Adjusted Claims after the end of the Claims Runout Period.

b. The fee for providing Claims Runout Services during the Claims Runout Period, if applicable, is provided in Section 6 of Schedule A. Paid Claims and the fee for providing Claims Runout Services shall be invoiced and paid in the same manner as provided in Sections 4 and 5 of Schedule A, unless otherwise provided or agreed to in writing by the Parties.

ARTICLE 8 - LATE PAYMENT PENALTY

If applicable, Employer agrees to reimburse Anthem for any expenses charged to Anthem by a financial institution, Provider or Vendor due to Employer's failure to maintain sufficient funds in a designated bank account.

ARTICLE 9 - HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

a. Anthem's duties and responsibilities in connection with the requirements imposed by the Health Insurance Portability and Accountability Act ("HIPAA&") and the Privacy, Security, Breach Notification and Standard Transactions regulations promulgated thereunder will be set forth in a separate Business Associate Agreement between the Parties. Business Associate is defined as a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a Covered Entity, as defined under 45 CFR 160.103. Business Associate Agreement is defined as a legal contract that describes how Anthem, as a Business Associate, and Plan, as a Covered Entity, may use or disclose protected health information so that the Plan may comply with the applicable requirements of HIPAA and its regulations.

b. In the event the Plan submits Claims or eligibility inquiries or any other HIPAA covered transaction as defined in 45 CFR Part 160 and 162 to Anthem through electronic means, the Plan and Anthem shall comply with all applicable requirements of HIPAA and the Plan and Anthem shall require any of their respective agents or subcontractors to comply with all applicable requirements of HIPAA.

ARTICLE 10 - PROPRIETARY AND CONFIDENTIAL INFORMATION

a. Each Party retains ownership of its Proprietary Information and Confidential Information (collectively "Information") and neither conveys ownership rights in its Information nor acquires ownership rights in the other Party's Information by entering into this Agreement or performing its obligations hereunder. Nothing in this Agreement shall impair or limit a Party's right to use and disclose its Information for its own lawful business purposes.

b. Each Party shall maintain the other Party's Information in strict confidence, and shall institute commercially reasonable safeguards to protect it.

c. Employer shall use and disclose Anthem's Information solely for the purpose of administering the Plan. Employer shall not, without Anthem's advance written consent, (1) use or disclose Anthem's Information, or reports or summaries thereof, for any purpose other than administering the Plan; (2) combine Anthem's Information with other data to create or add to an aggregated database that will or could be made available to any third party; (3) combine Anthem's Information provided for a particular purpose with Anthem's Information provided for another purpose; or (4) sell or disclose Anthem's Information to any other person or entity except as expressly permitted by this Article 10.

d. Employer may disclose the minimum amount of Anthem's Information necessary to Employer's stop loss carriers, consultants, auditors, and other third parties engaged by Employer (each a "Plan Contractor"), provided that: (i) each such Plan Contractor needs to know such Information in order to provide services to Employer; (ii) the restrictions set forth in subsection c. of this Article 10 shall apply to each such Plan Contractor as well as to Employer; and (iii) prior to such disclosure, each such Plan Contractor shall enter into Anthem confidentiality agreement. Notwithstanding the foregoing, Plan Contractor shall not be required to execute a confidentiality agreement prior to the planned disclosure if a confidentiality agreement between Anthem and Plan Contractor is in effect when such disclosure is made. A sample copy of Anthem’s confidentiality agreement shall be provided upon request.

e. Upon termination of this Agreement, each Party shall return or destroy the other Party's Information or retain the Information in accordance with its reasonable record retention policies and procedures; provided; however that each Party shall continue to comply with the provisions of this Article 10 for as long as it retains the other Party's Information.

f. This Agreement shall not be construed to restrict the use or disclosure of information that: (1) is public knowledge other than as a result of a breach of this Agreement; (2) is independently developed by a Party not in violation of this Agreement; (3) is made available to a Party by any person other than the other Party, provided the source of such information is not subject to any confidentiality obligations with respect to it; (4) is required to be disclosed pursuant to law, order, regulation or judicial or administrative process, but only to the extent of such required disclosures and after reasonable notice to the other Party; or (5) is required to be disclosed to a Member.

ARTICLE 11 - DATA REPORTS

a. Anthem shall provide online data reports that are part of Anthem’s standard account reporting package. In addition, upon Employer’s request, Anthem shall provide data reports that are not part of Anthem’s standard account reporting package for an additional fee as set forth in Schedule A. Prior to Anthem providing data reports to Employer, the Parties must mutually agree to the types, format, content and purpose of the reports. Any agreement by Anthem to provide non-standard reports shall be considered confidential. Employer and its Plan Contractors agree not to disclose, promote, or advertise the non-standard reporting arrangement or fee agreed to under this paragraph.

b. If Employer requests Anthem to provide a data extract or report to any Plan Contractor for use on Employer's behalf and Anthem agrees to do so: (1) to the extent such extract or report includes protected health information ("PHI") as defined in HIPAA, Anthem's disclosure of the PHI and Plan Contractor's subsequent obligations with respect to the protection, use, and disclosure of the PHI will be governed by Employer's applicable business associate agreements with Anthem and the Plan Contractor; and (2) to the extent such data or report includes Anthem's Proprietary Information and/or Anthem's Confidential Information, Employer acknowledges and agrees that Plan Contractor shall be subject to the requirements set forth in Article 10 of this Agreement.

c. Employer agrees not to contact, or to engage or permit a Plan Contractor to contact on Employer's behalf, any Provider concerning the information in any reports or data extracts provided by Anthem unless the contact is coordinated by Anthem.

d. In addition to their unlimited rights to use Anthem's Proprietary Information and Confidential Information, Anthem and Anthem Affiliates shall also have the right to use and disclose other Claim-related data collected in the performance of services under this Agreement or any other agreement between the Parties, so long as such use and disclosure is in compliance with HIPAA. Examples of such use and disclosure include: (1) the use and disclosure of data that is de-identified in a manner consistent with the requirements of HIPAA; (2) the use and disclosure of data is for research, health oversight activities, or as otherwise permitted in the applicable Business Associate Agreement; and (3) the release of individually identifiable data following Member direction, including by authorization.

e. If any data provided pursuant to Article 11(a) or Article 11(b) is used to conduct an audit or any type of review of Claim payment outcomes and Employer requests that Anthem research the findings, such request shall be considered a Claims Audit pursuant to Article 12. As described in Article 2(b)(1), Article 2(o), and Article 2(s), Employer acknowledges that Anthem's reimbursement policies and procedures may differ from those of a Plan Contractor and that Anthem's reimbursement policies and procedures shall control the findings of any audit. A maximum of 250 Claims will be reviewed by Anthem under this paragraph, and Employer agrees to pay the data audit fee set forth in Schedule A.

ARTICLE 12 - CLAIMS AUDIT

a. At Employer's expense, Employer shall have the right to audit Claims, during regular business hours and in accordance with Anthem's audit policy, which may be revised from time to time. A copy of the audit policy shall be made available to Employer upon request.

b. If Employer elects to utilize a third-party auditor to conduct an audit pursuant to this Agreement and Anthem's audit policy, such auditor must be mutually acceptable to Employer and Anthem. Anthem will only approve auditors that are independent and objective and will not approve auditors paid on a contingency fee or other similar basis. Anthem reserves the right to charge a fee to Employer as described in Anthem's audit policy for expenditure of time by Anthem's employees in completing any audit. An auditor or consultant must execute Anthem's confidentiality agreement pertaining to Anthem's Proprietary Information and Confidential Information prior to conducting an audit to the extent that a confidentiality agreement is not already in place.

c. Employer may conduct an audit once each calendar year and the audit may only relate to Claims processed during the current year or immediately preceding calendar year (the "Audit Period") and neither Employer nor anyone acting on Employer's or the Plan's behalf, shall have a right to audit Claims processed prior to the Audit Period. The scope of the audit shall be agreed to in writing by the Parties prior to the commencement of the audit.

d. Employer shall provide to Anthem copies of draft, interim and/or final audit reports at such time as they are made available by the auditor or consultants to Employer. Any errors identified and/or amounts identified as owed to Employer as the result of the audit shall be subject to Anthem's review and approval prior to initiating any recoveries of Paid Claims pursuant to Article 13 of this Agreement. Anthem reserves the right to terminate any audit being performed by or for Employer if Anthem determines that the confidentiality of its information is not properly being maintained or if Anthem determines that Employer or auditor is not following Anthem's audit policy.

e. An audit performed pursuant to this Agreement shall be the final audit for the Audit Period and for any prior Audit Period unless otherwise agreed to in writing by the Parties.

ARTICLE 13 - RECOVERY AND PREPAYMENT ANALYSIS SERVICES

a. Pursuant to the provisions of this Article 13(a), Anthem shall conduct recovery activities including review of Paid Claims processed under this Agreement (including during any Claims Runout Period) and audits of Provider and Vendor contracts. The purpose of these services is to determine whether Paid Claims processed under this Agreement have been paid accurately and identify recoveries that can be pursued. Anthem shall not be obligated to retain outside counsel or other third parties if Anthem's recovery efforts are not successful. If Anthem makes a recovery as a result of the services described in this Article 13(a), then Anthem shall receive a fee provided in Schedule A as compensation for its services, except in instances of Anthem's sole error or Provider voluntary reimbursement, and Employer will receive the remaining recovery amount.

   Anthem shall also engage in various Claims prepayment analysis activities. These activities analyze Claims after services are rendered by a Provider or Vendor but prior to Claims payment to determine whether the billing and Claims submission are accurate and are intended to prevent inaccurate payments from being made. In addition, Anthem may analyze Claims to identify aberrant Provider billing practices and conduct interventions which are designed to ensure that Provider billing practices conform to nationally recognized coding and billing guidelines. If the amount charged to Employer as a Paid Claim is less than the amount that would have been charged to Employer absent the services described in this Article 13(a), then Anthem shall be entitled to receive the fee provided in Schedule A as compensation for its services. This fee shall only be charged where the prepayment analysis activities relate to a specific Claim(s).

b. Anthem may become aware of additional recovery opportunities by means other than those described in Article 13(a). Employer grants Anthem the authority and discretion in those instances to do the following: (1) determine and take steps reasonably necessary and cost-effective to pursue the recovery such as filing a proof of claim in a class action settlement, commencing litigation, opting out of or objecting to a proposed settlement, and/or engaging in settlement negotiations; (2) select and retain outside counsel when needed; (3) reduce any recovery obtained on behalf of the Plan by its proportionate share of the outside counsel fees and costs incurred during litigation or settlement activities to obtain such recovery; and (4) implement or effect any settlement of the Employer's and Plan's rights by, among other things, executing a release waiving the Employer's and Plan's rights to take any action inconsistent with the settlement.

c. During the term of this Agreement and any applicable Claims Runout Period, Anthem may pursue payments to Members by any other person, insurance company or other entity on account of any action, claim, request, demand, settlement, judgment, liability or expense that is related to a Claim for Covered Services ("Subrogation Services"). Anthem shall charge Employer a fee provided in Schedule A to this Agreement ("Subrogation Fee"). Any subrogation recoveries shall be net of the Subrogation Fee. Subrogation Fees will not be assessed on subrogation recoveries until they are received by Anthem and credited to Employer.

d. This provision is intentionally omitted.

e. In exercising its authority pursuant to this Article 13, Anthem shall determine which recoveries it will pursue or Claims that it will review prior to payment, and in no event will Anthem pursue a recovery if it reasonably believes that the cost of the collection is likely to exceed the recovery amount or if the recovery is prohibited by law or an agreement with a Provider or Vendor. Anthem will not be liable for any amounts it does not successfully recover or prevent from being paid based on Claims prepayment analysis activities. Anthem shall retain any recoveries it obtains as a result of its recovery services or audits if the cost to administer the refund is likely to exceed the amount of the refund. Employer further understands and agrees that Anthem shall have authority to enter into a settlement or compromise on behalf of the Employer and Plan regarding these recovery, subrogation and audit services, including, but not limited to, the right to reduce future reimbursement to Provider or Vendor in lieu of a lump sum settlement. Anthem may adjust Claims by offsetting or cross-plan offsetting as described in Article 4. Anthem may have contracts with Network Providers or Vendors or there may be judgments, orders, settlements, applicable laws or regulations that limit, under certain circumstances, Anthem's right to make recoveries or engage in Claims prepayment analysis activities. Anthem may, but is not required to, readjudicate Claims or adjust Members' cost share payments related to the recoveries made from a Provider or a Vendor. Anthem shall credit Employer net recovery amounts after deduction of fees and costs as set forth in this Article 13 not later than 150 days following the receipt of the total recovery amount. If Anthem does not credit Employer within 150 days of its receipt of the total recovery amount, Anthem shall pay Employer interest calculated at the Federal Reserve Funds Rate in effect at the time of the payment. In no event, however, will Anthem be liable to credit Employer for any recovery after the termination date of this Agreement and any Claims Runout Period, and Employer acknowledges and agrees that such sums shall be retained by Anthem as reasonable compensation for recovery services provided by Anthem.

ARTICLE 14 - PHARMACY BENEFITS AND SERVICES

This Article is intentionally omitted.

ARTICLE 15 - INTER-PLAN ARRANGEMENTS

This Article is intentionally omitted and replaced by the Inter-Plan Arrangements Schedule.

ARTICLE 16 - CLAIMS LITIGATION

a. For purposes of Articles 16 and 17 of this Agreement, "Claims Litigation" means a demand asserted or litigation, proceedings, or arbitration commenced, by a Member, Plan beneficiary or Network or non-Network Provider, or any individual or entity working on any of their behalf ("Claimant(s)"), regardless of how pled or how asserted, where the Claimant seeks to recover monetary damages (including but not limited to actual, compensatory, punitive or other damages), equitable relief, declaratory relief, attorneys' fees, costs, expenses, or other relief, in connection with Anthem's alleged failure to properly handle a request for Covered Services or to pay for all or any portion of Covered Services, including any allegations related to the sufficiency of the amount paid for all or any portion of a Covered Service. References to "Employer" in this Article 16 shall mean Employer or Plan or both as appropriate given the context.

b. Anthem shall direct the defense of any Claims Litigation brought against Anthem. If Employer (in addition to Anthem) is also a named party in the Claims Litigation, Anthem shall direct the defense of the Claims Litigation and the Employer will cooperate in defending against the Claims Litigation. Employer will direct the defense of the Claims Litigation where Anthem is not a named party. Unless there is a conflict that is not waived, in any of the above scenarios, if Anthem requests, Anthem and the Employer will enter a common interest and/or joint defense agreement to address the sharing of information and any other matters the Parties deem appropriate. Whether there is such a conflict or not, all other provisions of this Article 16 will continue to apply. Anthem shall provide notice of Claims Litigation to the Employer as soon as practicable; provided, however, that this notice obligation shall not apply to Claims Litigation brought by any Provider or to any Claims Litigation to which Employer is a named party.

c. For any Claims Litigation to which Anthem is a named party, Anthem will select and retain counsel for itself and, if Employer is also named, for the representation of Anthem and Employer contemplated by Article 16(b). If, at the outset or during such Claims Litigation, Employer and Anthem have a conflict of interest, the selected counsel shall represent Anthem only. Employer shall waive any conflict for such representation and retain separate counsel for Employer. Further, during and after the conclusion of Claims Litigation, Employer agrees that counsel selected and retained by Anthem to defend Claims Litigation may represent Anthem in any matter (historical, existing, or future) without seeking or requiring Employer's consent, including in litigation where Anthem's interests are or may be adverse to Employer. Subject to Article 16(d), Employer will assume liability for payment of all reasonable attorneys' fees and costs incurred by Anthem and/or Employer in the defense of Claims Litigation.

d. If it is determined by the third-party decision maker in the Claims Litigation that Anthem failed to perform its responsibility to review and determine Claims for benefits under the Plan in a manner that is consistent with the standard of care in Article 17 of this Agreement, Anthem will assume liability for payment of its legal fees and costs.

e. Anthem is authorized to settle or compromise any Claims Litigation with the approval of Employer, which approval shall not be unreasonably withheld. Notwithstanding the above, settlements of disputes brought by Providers do not require the approval of Employer.

f. Anthem is not an insurer of benefits under the Plan nor does it underwrite the risk or otherwise assume any risk for the payment of benefits under the Plan. Under all circumstances, Employer shall be liable to pay Plan benefits awarded or paid by settlement, judgment, or otherwise.

ARTICLE 17 - INDEMNIFICATION

Except for Claims Litigation, which is governed exclusively by Article 16 of this Agreement, Anthem and Employer shall each, to the extent permitted by law, indemnify, defend and hold harmless the other Party, and its directors, officers, employees, agents and affiliates, from and against any and all losses, claims, damages, liabilities, costs and expenses (including without limitation, reasonable attorneys' fees and costs) that are recovered in direct actions between the Parties or actions brought by a third party asserting liability for: (1) the indemnifying Party's or its subcontractor's gross negligence or willful misconduct in the performance of the obligations under this Agreement, including but not limited to the performance of obligations regarding compliance with HIPAA, HITECH, or applicable privacy or security laws pursuant to the Parties' Business Associate Agreement; (2) the indemnifying Party's failure to provide information required under this Agreement or otherwise required by law that results in a sanction or penalty being assessed against the other Party, and/or (3) the indemnifying Party's or its subcontractor's breach of fiduciary duties. The obligation to provide indemnification under this Agreement shall be contingent upon the Party seeking indemnification: (1) providing the indemnifying Party with prompt written notice of any claim for which indemnification is sought, (2) allowing the indemnifying Party to control the defense and settlement of such claim; provided, however, that the indemnifying Party agrees not to enter into any settlement or compromise of any claim or action in a manner that admits fault or imposes any restrictions or obligations on an indemnified Party without that indemnified Party's prior written consent, which will not be unreasonably withheld; and, (3) cooperating fully with the indemnifying Party in connection with such defense and settlement.

ARTICLE 18 - CHANGES IN BENEFITS BOOKLET AND AGREEMENT

a. Either Party reserves the right to propose changes to the provisions described in the Benefits Booklet by giving written notice to the other Party not less than 90 days prior to the start of an Agreement Period and such changes will be made to the Benefits Booklet as mutually agreed to in writing by the Parties. Either Party may also propose changes to the Benefits Booklet at a time other than the start of an Agreement Period and such changes will be made to the Benefits Booklet if mutually agreed to in writing by the Parties. Anthem's incorporation of the requested changes into the Benefits Booklet shall constitute Anthem's acceptance of the Employer's requested changes. If Anthem initiates the proposed changes and does not receive written notice from Employer prior to the effective date of the proposed changes that such changes are unacceptable, the changes shall be deemed approved by Employer and Anthem shall incorporate such changes into the Benefits Booklet.

b. If changes to the provisions of the Benefits Booklet are mandated as a result of a change to any applicable state or federal law, Anthem shall have the right to make such changes to the Benefits Booklet to comply with the law and shall use best efforts to provide written notice to Employer at least 30 days prior to the effective date of the change, unless the effective date specified in the law is earlier.

c. Anthem also reserves the right to change the Base Administrative Services Fee provided in Section 3(A) of Schedule A at a time other than the start of an Agreement Period upon the occurrence of one or more of the following events: (1) a change to the Plan benefits initiated by Employer that results in a substantial change in the services to be provided by Anthem; (2) a change in ownership as described in Article 3(h) of this Agreement; (3) a change in the total number of Members resulting in either an increase or decrease of 10% or more of the number of Members enrolled for coverage on the date the Base Administrative Services Fee was last modified; (4) a change in Employer contribution as described in Article 3(e) of this Agreement; (5) a change in nature of Employer's business resulting in a change in its designated Standard Industrial Classification ("SIC") code; or (6) a change in applicable law that results in an increase in the cost or amount of administrative services from those currently being provided by Anthem under this Agreement. Anthem shall provide notice to Employer of the change in the Base Administrative Services Fee at least 30 days prior to the effective date of such change. If such change is unacceptable to Employer, either Party shall have the right to terminate this Agreement by giving written notice of termination to the other Party before the effective date of the change. If Employer accepts the proposed Base Administrative Services Fee, Anthem shall provide a revised Schedule A that will then become part of this Agreement without the necessity of securing Employer's signature on the Schedule.

d. In the event any action of any department, branch or bureau of the federal, state or local government is initiated or taken ("Action") against a Party to this Agreement and such Action materially and adversely affects that Party's performance of the obligations under this Agreement, the affected Party shall notify the other Party of the nature of the Action and provide copies of pertinent documents supporting the reason(s) for the Action. If a modification to the Agreement is needed as a result of the Action, the Parties shall meet within 30 days of the notice by the affected Party to the other Party and shall, in good faith, attempt to negotiate a modification to this Agreement that minimizes or eliminates the impact of the Action. If the Parties are unable to minimize or eliminate the impact of the Action, then either Party may terminate this Agreement by giving at least 90 days notice of termination. This Agreement may be terminated sooner if agreed to by the Parties or required by the government entity initiating or taking the Action.

e. No modification or change in any provision of this Agreement shall be effective unless and until approved in writing by an authorized representative of Anthem and evidenced by an amendment or new Schedule attached to this Agreement. If Anthem proposes such a modification or change, Anthem shall provide written notice to Employer at least 30 days prior to the effective date of such change. The modification or change will be deemed accepted by Employer unless Anthem receives written notice from Employer prior to the effective date that such change is unacceptable. If Employer does not accept the proposed change, the Parties will meet and confer.

ARTICLE 19 - TERMINATION AND/OR SUSPENSION OF PERFORMANCE

a. Notwithstanding any other provision of this Article, this Agreement automatically terminates, without further notice or action, if Employer fails to pay or fund any amount due under this Agreement within 7 days of the date of Anthem's notice to the Employer of a delinquent amount owed. Such termination shall be effective as of the last period for which full payment was made. In addition, this Agreement automatically terminates, without further notice or action, at the end of each Agreement Period unless Anthem offers to renew this Agreement and Employer accepts such offer of renewal pursuant to Article 6 of this Agreement. Upon termination of this Agreement, Employer shall remain liable for all payments due to Anthem under the terms of this Agreement. Notwithstanding the above, Anthem has the right to suspend performance of its obligations under this Agreement if full payment is not made by the Invoice Due Date. Anthem shall have no obligation to pay any Claims under the Agreement until all required payments have been paid in full.

b. If either Party fails to comply with any material duties and obligations under this Agreement other than payment of amounts due under this Agreement, the other Party shall have the right to: (1) terminate this Agreement by giving the non-compliant Party at least 60 days prior written notice of termination; or (2) upon written notice to the other Party, suspend performance of its obligations under this Agreement. Employer acknowledges and agrees that in the event it is the non-compliant Party, Anthem shall have no liability to any Member. Either Party, at its option, may allow the non-compliant Party to cure a breach of this Agreement and, upon acceptance in writing by that Party that a breach is cured, this Agreement may be reinstated retroactive to the date of the breach or suspension of performance. Notwithstanding any other provision of this Agreement, a Party may seek injunctive or other equitable relief from a court of competent jurisdiction should there be any unauthorized use or disclosure of Proprietary Information or Confidential Information by the other Party.

c. If there shall occur any change in the condition (financial or otherwise) of Employer or an Employer Affiliate that, in the reasonable opinion of Anthem, has a material adverse effect upon the validity, performance, or enforceability of this Agreement, on the financial condition or business operation of Employer (or Employer Affiliate), or on the ability of Employer to fulfill its obligations under this Agreement, then Anthem shall have the right to require Employer to provide adequate assurance of future performance, which may include a payment of a cash deposit, letter of credit, or other method of assurance acceptable to Anthem. Examples of such a change could include, but would not be limited to the actual, or Anthem's reasonable anticipation of: (1) any voluntary or involuntary case or proceedings under bankruptcy law with respect to Employer or an Employer Affiliate; (2) any receivership, liquidation, dissolution, reorganization or other similar case or proceeding with respect to Employer or an Employer Affiliate; (3) any appointment of a receiver, trustee, custodian, assignee, conservator or similar entity or official for Employer or an Employer Affiliate; or (4) any assignment for the benefit of creditors or sale of all or substantially all of Employer's assets or a key Employer Affiliate's assets.

Any deposit amount shall be paid to Anthem within 30 days of the request or in such shorter time as agreed to by the Parties. The deposit amount shall not be paid with Plan assets, shall not be funded in any part by Member contributions, and shall not be paid from any segregated fund or from funds in which the Plan or any Member has a beneficial interest. The deposit amount shall be the property of Anthem, may be held in Anthem's general account, may be subject to satisfy the claims of Anthem's general creditors, and does not govern or limit the benefits available under the terms of the Plan. At the termination of this Agreement and designated Claims Runout Period, if any, the deposit amount, net of any outstanding fees or Claims amounts payable to Anthem, shall be returned to Employer. Any deposit amount returned to Employer under this Article 19(c) shall not include interest. Neither Employer, the Plan, nor any Member shall have any beneficial or legal ownership interest in any deposit amount paid pursuant to this Section.

If such further assurance is required by Anthem, Anthem may, at any time after the date of notice to Employer of such requirement, suspend performance of its obligations under this Agreement until the date of receipt by Anthem of such adequate assurance without being liable to the Employer, the Plan or any Member for such suspension. If such adequate assurance is not received within 30 days of the request, Anthem may terminate this Agreement.

d. Subject to the provisions of Article 7 of this Agreement, if this Agreement terminates and Anthem makes payment of any Claim that would otherwise have been payable under the terms of this Agreement after the termination date, Employer shall be liable to reimburse Anthem for such Claim to the extent that the amounts have not already been paid by Employer.

e. Employer may terminate this Agreement at any time other than at the end of an Agreement Period by giving Anthem 90 days written notice of its intent to terminate.

ARTICLE 20 - LIMITATION ON ACTIONS AND GOVERNING LAW

a. No legal action by either Party under this Agreement may be commenced after the expiration of 3 years from the date on which the claim arose.

b. This Agreement shall be governed by, and shall be construed in accordance with the laws of Colorado but without giving effect to that state's rules governing conflict of laws.

ARTICLE 21 - NO WAIVER

No failure or delay by either Party to exercise any right or to enforce any obligation herein, and, no course of dealing between Employer and Anthem, shall operate as a waiver of such right or obligation or be construed as or constitute a waiver of the right to enforce or insist upon compliance with such right or obligation in the future. Any single or partial exercise of any right or failure to enforce any obligation shall not preclude any other or further exercise, or the right to exercise any other right or enforce any other obligation.

ARTICLE 22 - ASSIGNMENT AND SUBCONTRACTING

a. Unless it has first obtained the written consent of an officer of the other Party, neither Party may assign this Agreement to any other person. Notwithstanding the foregoing, Anthem may, with advance written notice to Employer, assign or otherwise transfer its rights and obligations hereunder, in whole or in part, to: (1) any affiliate of Anthem; or (2) any entity surviving a transaction involving the merger, acquisition, consolidation, or reorganization of Anthem, or in which all or substantially all of Anthem's assets are sold. Additionally, Employer may, with advance written notice to Anthem, assign, delegate, or otherwise transfer its rights and obligations hereunder, in whole, to (1) any affiliate of Employer; or (2) any entity surviving a transaction involving the merger, acquisition, consolidation or reorganization of Employer, or in which all or substantially all of Employer's assets are sold, provided that such affiliate or other assignee presents, in Anthem's opinion, an equivalent or better financial status and credit risk. Either Party is required to provide advance written notice under this provision only to the extent permissible under applicable law and the reasonable terms of the agreement(s) governing such merger, acquisition, consolidation, reorganization, or asset sale. If advance written notice is not allowed, notice shall be provided as soon as practicable. Upon receipt of notice of an assignment of this Agreement, the other Party may terminate this Agreement by providing the assigning Party with 30 days advance written notice of termination. Any assignee of rights or benefits under this Agreement shall be subject to all of the terms and provisions of this Agreement.

b. Either Party may subcontract any of its duties under this Agreement without the prior written consent of other Party; however, the Party subcontracting the services shall: (1) ensure that each subcontractor complies with applicable laws and regulations; and (2) remain responsible for fulfilling its obligations under this Agreement.

ARTICLE 23 - NOTICES

a. Any notice or demand pursuant to this Agreement shall be deemed sufficient when made in writing as follows: to Employer, by first class mail, personal delivery, or electronic mail or overnight delivery with confirmation capability, to its principal office shown upon the records of Anthem; to Anthem, by first class mail, personal delivery, electronic mail or overnight delivery with confirmation capability, to the designated Anthem sales representative.

b. A notice or demand shall be deemed to have been given as of the date of deposit in the United States mail with postage prepaid or, in the case of delivery other than by mail, on the date of actual delivery at the appropriate physical or electronic mail address.

c. Employer shall be obligated to provide all notices to Members as may be necessary to effectuate any change in or termination of the Agreement.

ARTICLE 24 - ADMINISTRATION

a. Employer, on behalf of itself and its Members, hereby expressly acknowledges its understanding that this Agreement constitutes a contract solely between Employer and Anthem, that Anthem is an independent corporation operating under a license with BCBSA permitting Anthem to use the Blue Cross and/or Blue Shield Service Marks in Colorado and that Anthem is not contracting as the agent of BCBSA. Employer further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Anthem and that no person, entity, or organization other than Anthem shall be held accountable or liable to it for any of Anthem's obligations to Employer created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this Agreement.

b. Anthem is providing administrative services only with respect to the portion of the Plan described in the Benefits Booklet. Anthem has only the authority granted it pursuant to this Agreement. Anthem is not the insurer or underwriter of any portion of the Plan. Anthem has no responsibility or liability for funding benefits provided by the Plan, notwithstanding any advances that might be made by Anthem. Employer retains the ultimate responsibility and liability for all benefits and expenses incident to the Plan, including but not limited to, any applicable taxes that might be imposed relating to the Plan.

c. This provision has been intentionally deleted in its entirety.

d. Employer shall ensure that sufficient amounts are available to cover Claims payments, the monthly Administrative Services Fees, and other fees or charges.

ARTICLE 25 - ENTIRE AGREEMENT

a. The following documents will constitute the entire Agreement between the Parties: this Agreement, including any amendments and Schedules thereto, and the Benefits Booklet.

b. This Agreement may be executed simultaneously in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. An electronic signature, including facsimile, shall be deemed equivalent to an original ink signature.

c. This Agreement supersedes any and all prior agreements between the Parties, whether written or oral, and other documents, if any, addressing the subject matter contained in this Agreement.

d. If any provision of this Agreement is held to be invalid, illegal or unenforceable in any respect under applicable law, order, judgment or settlement, such provision shall be excluded from the Agreement and the balance of this Agreement shall be interpreted as if such provision were so excluded and shall be enforceable in accordance with its terms.

ARTICLE 26 - THIS ARTICLE IS INTENTIONALLY OMITTED

ARTICLE 27 - MISCELLANEOUS

a. Employer and Anthem are separate legal entities. Nothing in this Agreement shall be construed to create any third party beneficiaries. Anthem is strictly an independent contractor. Nothing contained in this Agreement shall cause either Party to be deemed a partner, member, agent or representative of the other Party, nor shall either Party have the expressed or implied right or authority to assume or create any obligation on behalf of or in the name of the other Party through its actions, omissions or representations.

b. Except as may be explicitly set forth in this Agreement, nothing herein shall be construed as an implied license by a Party to use the other Party's name, trademarks, domain names, or other intellectual property. Neither Party shall use the name, trademarks, domain names, or any other name or mark of the other Party in any press release, printed form, advertising or promotional materials or otherwise, without the prior written consent of the other Party. In addition, Employer has no license to use the Blue Cross and/or Blue Shield trademarks or derivative marks (the "Brands") and nothing in the Agreement shall be deemed to grant a license to Employer to use the Brands. Any references to the Brands made by Employer in its own materials are subject to prior review and approval by Anthem.

c. Nothing contained herein shall cause either Party to be deemed an agent for service of legal process for the other Party.

d. As part of building its Provider network, Anthem or an Anthem Affiliate may enter into business arrangements with certain Network Providers and Anthem may have financial interest in such Network Providers through direct ownership, partnership, joint venture or other arrangements. The business arrangements may provide practice management or other services to Network Providers that are designed to promote a more effective and cost-efficient health care delivery system that emphasizes continuous improvement and increased patient access to high quality, cost-effective health care. Because of its ownership or financial interests in Network Providers, Anthem may share in the Network Provider's profits or other revenue. Any revenue received by Anthem in connection with these business arrangements shall be retained by Anthem.

e. The Parties acknowledge that Anthem, in making decisions regarding the scope of coverage of services under the Benefits Booklet, is not engaged in the practice of medicine. Providers are not restricted in exercising their independent medical judgment by contract or otherwise and do not act on behalf of, or as agents for, Anthem or the Plan.

f. In addition to any other provision providing for survival upon termination of this Agreement and any applicable Claims Runout Period, the Parties' rights and obligations under Articles 9, 10, 13, 16, 17, 19(d), 20, 25(a), 25(c), 27(a) and 27(b) shall survive the termination of this Agreement for any reason.

g. Each Party shall comply with all laws and regulations applicable to their respective duties and obligations assumed under this Agreement.

h. Anthem and Employer agree to the performance standards set forth in Schedule C.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by affixing the signatures of duly authorized officers.

City of Littleton	Rocky Mountain Hospital and Medical Service, Inc. dba Anthem Blue Cross and Blue Shield
By: _____	By: _____
Kyle Schlachter, Mayor	Matt Pickett, Plan President
Date: _____	Date: _____

APPROVED AS TO FORM:

By:_____

Reid Betzing, City Attorney

Date:_____

INTER-PLAN ARRANGEMENTS SCHEDULE
TO ADMINISTRATIVE SERVICES AGREEMENT
WITH
City of Littleton

This Inter-Plan Arrangement Schedule supplements and amends the Administrative Services Agreement and is effective as of January 1, 2026. In the event of an inconsistency between the applicable provisions of this Schedule, any other Schedule and/or the Agreement, the terms of this Schedule shall govern, but only as they relate to the Inter-Plan Arrangements. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

Out-of-Area Services

Overview

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements". These Inter-Plan Arrangements operate under rules and procedures issued by BCBSA. Whenever Members access healthcare services outside the geographic area Anthem serves (the "Anthem Service Area"), the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the Anthem Service Area, Members obtain care from healthcare Providers that have a contractual agreement ("Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from healthcare Providers in the Host Blue geographic area that do not have a contractual agreement ("Non-Participating Providers") with the Host Blue. Anthem remains responsible for fulfilling its contractual obligations to Employer. Anthem's payment practices in both instances are described below.

This disclosure describes how Claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements. Note that dental care, Prescription Drug or vision benefits may not be processed through Inter-Plan Arrangements.

If the Plan covers only limited healthcare services received outside of Anthem's Service Area, services other than those listed as Covered Services (e.g., emergency services) in the Plan will not be covered when processed through any Inter-Plan Arrangements, unless authorized by Anthem. Providers providing such non-Covered Services will be considered Non-Participating Providers.

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access Covered Services outside the Anthem Service Area, the Host Blue will be responsible for contracting and handling all interactions with its Participating Providers. The financial terms of the BlueCard Program are described generally below.

1. Liability Calculation Method Per Claim

a. Member Liability Calculation

Unless subject to a fixed dollar copayment, the calculation of the Member liability on Claims for Covered Services will be based on the lower of the Participating Provider's Billed Charges or the negotiated price made available to Anthem by the Host Blue.

b. Employer Liability Calculation

The calculation of Employer liability on Claims for Covered Services will be based on the negotiated price made available to Anthem by the Host Blue. Sometimes, this negotiated price may be greater for a given service or services than the Billed Charges in accordance with how the Host Blue has negotiated with its Participating Provider(s) for specific healthcare services. In cases where the negotiated price exceeds the Billed Charges, Employer may be liable for the excess amount even when the Member's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the Provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the Participating Provider, even when the contracted price is greater than the Billed Charges.

2. Claims Pricing

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's Participating Provider contracts. The negotiated price made available to Anthem by the Host Blue may be represented by one of the following:

(i) An actual price. An actual price is a negotiated rate of payment in effect at the time a Claim is processed without any other increases or decreases; or

(ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a Claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other Claim- and non-Claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a Claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

(iii) An average price. An average price is a percentage of Billed Charges in effect at the time a Claim is processed representing the aggregate payments negotiated by the Host Blue with all of its Participating Providers or a similar classification of its Participating Providers and other Claim- and non-Claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether it will use an actual, estimated or average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price Employer pays on a specific Claim and the actual amount the Host Blue pays to the Participating Provider. However, the BlueCard Program requires that the amount paid be a final price; no future price adjustment will result in increases or decreases to the pricing of past Claims.

Any positive or negative differences in estimated or average pricing are accounted for through variance accounts maintained by the Host Blue and are incorporated into future Claim prices. As a result, the amounts charged to Employer will be adjusted in a following year, as necessary, to account for over- or under-estimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from Employer. Upon termination, Employer will not receive a refund or charge from the variance account.

Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of Claims processed and variance account balance. Variance account balances may earn interest at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

B. Negotiated Arrangements

With respect to one or more Host Plans, instead of using the BlueCard Program, Anthem may process Claims for Covered Services through negotiated arrangements. A negotiated arrangement is an agreement negotiated between Anthem and one or more Host Blues for any group health plan that is not delivered through the BlueCard Program ("Negotiated Arrangement").

In addition, if Anthem and Employer agree that (a) Host Blue(s) shall make available (a) custom healthcare Provider network(s) in connection with this Agreement, then the terms and conditions set forth in Anthem's Negotiated Arrangement(s) with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of Claims when Members access such network(s). In negotiating such arrangement(s), Anthem is not acting on behalf of or as an agent for Employer, the Plan or Members.

Member Liability Calculation

If Anthem has entered into a Negotiated Arrangement with a Host Blue, the calculation of Member cost-sharing will be based on the lower of either Billed Charges or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) that the Host Blue makes available to Anthem and that allows Members access to negotiated participation agreement networks of specified Participating Providers outside of Anthem's service area.

C. Special Cases: Value-Based Programs

Definitions

1. **Accountable Care Organization (ACO):** A group of Providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.
2. **Care Coordination:** Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.
3. **Care Coordinator:** An individual within a Provider organization who facilitates Care Coordination for patients.
4. **Care Coordinator Fee:** A fixed amount paid by a Host Plan to Providers periodically for Care Coordination under a Value-Based Program.
5. **Global Payment/Total Cost of Care:** A payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient, such as outpatient, physician, ancillary, hospital services, and prescription drugs.
6. **Patient-Centered Medical Home (PCMH):** A model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.
7. **Provider Incentive:** An additional amount of compensation paid to a Provider by a Host Blue, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.
8. **Shared Savings:** A payment mechanism in which the Provider and the payer share cost savings achieved against a target cost budget based on agreed upon terms and may include downside risk.
9. **Value-Based Program (VBP):** An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

Value-Based Programs Overview

Members may access Covered Services from Providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

Value-Based Programs under the BlueCard Program

Value-Based Programs Administration

Under Value-Based Programs, a Host Blue may pay Providers for reaching agreed-upon cost/quality goals in the following ways: retrospective settlements, Provider Incentives, a share of target savings, Care Coordinator Fees and/or other allowed amounts.

The Host Blue may pass these Provider payments to Anthem, which Anthem will pass directly on to Employer as either an amount included in the price of the Claim or an amount charged separately in addition to the Claim.

When such amounts are included in the price of the Claim, the Claim may be billed using one of the following pricing methods, as determined by the Host Blue:

(i) Actual Pricing: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the Claim. These charges are passed to Employer via an enhanced Provider fee schedule.

(ii) Supplemental Factor: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is a supplemental amount that is included in the Claim as an amount based on a specified supplemental factor (e.g., a small percentage increase in the Claim amount). The supplemental factor may be adjusted from time to time. This pricing method may be used only for non-attributed Value-Based Programs.

When such amounts are billed separately from the price of the Claim, they may be billed using a Per Member Per Month billing for Value-Based Programs incentives/Shared Savings settlements to accounts outside of the Claim system. Anthem will pass these Host Blue charges directly through to Employer as a separately identified amount on the Employer billings.

The amounts used to calculate either the supplemental factors for estimated pricing or PMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard Claim pricing section above) until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, Host Blues will take one of the following actions:

- Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.

- Address any deficit in funds in the variance account through an adjustment to the PMPM billing amount or the reconciliation billing amount for the next measurement period.

The Host Blue will not receive compensation resulting from how estimated, average or PMPM price methods, described above, are calculated. If the Agreement terminates, Employer will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of this Agreement.

Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of Claims processed and variance account balance. Variance account balances may earn interest, and interest is earned at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

Note: Members will not bear any portion of the cost of Value-Based Programs except when a Host Blue uses either average pricing or actual pricing to pay Providers under Value-Based Programs.

Care Coordinator Fees

Host Blues may also bill Anthem for Care Coordinator Fees for Provider services which Anthem will pass on to Employer as follows:

1. PMPM billings; or

2. Individual Claim billings through applicable care coordination codes from the most current editions of either Current Procedural Terminology (CPT) published by the American Medical Association (AMA) or Healthcare Common Procedure Coding System (HCPCS) published by the U.S. Centers for Medicare and Medicaid Services (CMS).

Anthem and Employer will not impose Member cost-sharing for Care Coordinator Fees.

Value-Based Programs under Negotiated Arrangements

If Anthem has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Members, Anthem will follow the same procedures for Value-Based Programs administration and Care Coordination Fees as noted above.

D. Non-Participating Providers Outside Anthem's Service Area

1. Allowed Amounts and Member Liability Calculation

Unless otherwise described in the Plan, when Covered Services are provided outside of Anthem's Service Area by Non-Participating Providers, Anthem may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount the Member pays for such services as deductible, copayment or coinsurance will be based on that allowed amount. Also, the Member may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment Anthem will make for the covered services as set forth in this paragraph.

2. Exceptions

In certain situations, which may occur at Employer's direction, Anthem may use other pricing methods, such as Billed Charges, the pricing Anthem would use if the healthcare services had been obtained within Anthem's Service Area, or a special negotiated price to determine the amount Anthem will pay for services provided by Non-Participating Providers. In these situations, the Member may be liable for the difference between the amount that the Non-Participating Provider bills and the payment Anthem makes for the Covered Services as set forth in this paragraph.

E. Blue Cross Blue Shield Global Core®

General Information

If Members are outside the United States (hereinafter, "BlueCard Service Area"), they may be able to take advantage of Blue Cross Blue Shield Global Core® when accessing Covered Services. The Blue Cross Blue Shield Global Core is not served by a Host Blue. As such, when Members receive care from Providers outside the BlueCard Service Area, Members will typically have to pay the Providers and submit the Claims themselves to obtain reimbursement for these services.

Inpatient Services

In most cases, if Members contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require Members to pay for covered inpatient services, except for their cost-share amounts. In such cases, the hospital will submit Member Claims to the Blue Cross Blue Shield Global Core Service Center to initiate Claims processing. However, if the Member paid in full at the time of service, the Member must submit a Claim to obtain reimbursement for Covered Services. Members must contact Anthem to obtain precertification for non-emergency inpatient services.

Outpatient Services

Physicians, urgent care centers and other outpatient Providers located outside the BlueCard Service Area will typically require Members to pay in full at the time of service. Members must submit a Claim to obtain reimbursement for Covered Services.

F. Recoveries

Host Blues may conduct: (i) prepayment review activities including, but not limited to, data mining, itemized bill reviews, secondary claim code editing, and DRG audits and (ii) recoveries of overpayments including, but not limited to, anti-fraud and abuse reviews, audits/healthcare Provider/hospital bill audits, credit balance audits, and utilization review refunds (collectively, for (i) and (ii), "Recoveries"). Recoveries will be applied, in general, on either a Claim-by-Claim or prospective basis. If Recoveries are passed on a Claim-by-Claim basis from a Host Blue to Anthem, they will be credited to Employer. In some cases, the Host Blue will engage a third party to assist in identification related to Recoveries, including collection of overpayments. Employer may be charged a fee for Recoveries as described in Schedule A.

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, Anthem will request the Host Blue to provide full refunds from Participating Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original Claim. In some cases, recovery of Claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare Provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements, and Care Coordination Fees or (c) would jeopardize the Host Blue's relationship with its Participating Providers, notwithstanding to the contrary any other provision of this Agreement.

G. Modifications or Changes to Inter-Plan Arrangement Fees or Compensation

Modifications or changes to Inter-Plan Arrangement fees or compensation are generally made effective January 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes resulting in an increase in fees paid by Employer, Anthem shall provide Employer with at least thirty (30) days' advance written notice of any modification or change to such Inter-Plan Arrangement fees or compensation describing the change and the effective date thereof and Employer right to terminate this Agreement without penalty by giving written notice of termination before the effective date of the change. If Employer fails to respond to the notice and does not terminate this Agreement during the notice period, Employer will be deemed to have approved the proposed changes, and Anthem will then allow such modifications to become part of this Agreement.

H. Fees and Compensation

Employer understands and agrees to reimburse Anthem for certain fees and compensation which Anthem is obligated under the applicable Inter-Plan Arrangements described in this Schedule to pay to the Host Blues, to BCBSA and/or to vendors of Inter-Plan Arrangement related services. The specific Inter-Plan Arrangement fees and compensation, including any administrative and/or network access fee that a Host Blue may charge under the BlueCard Program, a Negotiated Arrangement, and Blue Cross Blue Shield Global Core are charged to Employer are set forth in Section 7 of Schedule A to the Agreement. The various Inter-Plan Arrangement Fees and compensation may be revised from time to time as described in section G.

A description of the various Claim processing fees that may be listed on Schedule A is as follows:

Access Fee: The Access Fee is charged by the Host Blue to Anthem for making its applicable Provider network available to Members. The Access Fee will not apply to Non-Participating Provider Claims. The Access Fee is charged on a per Claim basis and is charged as a percentage of the discount/differential Anthem receives from the applicable Host Blue subject to a maximum of $2,000 per Claim. When charged, Anthem passes the Access Fee directly on to Employer.

Instances may occur in which the Claim payment is zero or Anthem pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, Anthem will pay the Host Blue's Access Fee and pass it along directly to Employer as stated above even though Employer paid little or had no Claim liability.

Administrative Expense Allowance (AEA) Fee: The AEA Fee is a fixed per Claim dollar amount charged by the Host Blue to Anthem for administrative services the Host Blue provides in processing Claims for Employer's Members. The dollar amount is normally based on the type of Claim (e.g. institutional, professional, international, etc.) and can also be based on the size of group enrollment. When charged, Anthem passes the AEA Fee directly on to Employer.

Per Subscriber Per Month (PSPM) Fee: The PSPM Fee is a financial arrangement negotiated between the Host Blue and Anthem and replaces all other fees, including the Access Fee and AEA Fee. The PSPM dollar amount is charged on a per Subscriber per month basis by the Host Blue to Anthem for administrative services the Host Blue provides in processing Claims for Employer's Members. The dollar amount can also be based on the size of group enrollment. When charged, Anthem passes the PSPM Fee directly on to Employer.

Non-Standard AEA Fee: The Non-Standard AEA Fee is a financial arrangement negotiated between the Host Blue and Anthem and replaces all other fees, including the Access Fee and AEA Fee. The Non-Standard AEA is a fixed per Claim dollar amount charged by the Host Blue to Anthem for administrative services the Host Blue provides in processing Claims for Employer's Members. When charged, Anthem passes the Non-Standard AEA Fee directly on to Employer.

Central Financial Agency (CFA) Fee: The CFA Fee is a fixed dollar amount per payment notice and is paid by Anthem to the BCBSA. This fee applies each time Anthem receives an electronic payment notice from the CFA indicating that a Host Blue incurred Claim-related liability on Anthem's behalf and requesting that Anthem either approve or deny payment. When charged, Anthem passes the CFA Fee directly on to Employer. The CFA Fee supports ongoing operations of BCBSA programs and services, including but not limited to Blue Cross Blue Shield AXIS® Data Services, network solutions, and BlueCard Program-related applications.

Inter-Plan Teleprocessing System (ITS) Transaction Fee: The ITS delivery platform allows all Blue Cross and/or Blue Shield Licensees to connect with each other through a standardized system to facilitate the operation of Inter-Plan Arrangements. The ITS Transaction Fee applies each time a Claims transaction interchange occurs between Anthem and a Host Blue. When a Host Blue receives a Claim, it applies Provider pricing information, sets forth its discount and related savings and sends this information to Anthem electronically. Anthem then adjudicates the Claim, computes the approved Provider payment amount, calculates the AEA Fee and Access Fee, computes net liability and sends a response electronically to the Host Blue. The Host Blue then pays the Provider and issues an electronic payment notice to Anthem via the CFA. The ITS Transaction Fee is five cents per interchange and is paid to the BCBSA. For each Claim, there are a minimum of three interchanges, but there could be more depending on the complexity of the Claim. When charged, Anthem passes the ITS Transaction Fee directly on to Employer.

SCHEDULE A
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
City of Littleton

This Schedule A shall govern the Agreement Period from January 1, 2026 through December 31, 2026. For purposes of this Agreement Period, this Schedule shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms of the Agreement including any prior Schedules, and this Schedule A, the terms of this Schedule A shall control.

Section 1. Effective Date and Renewal Notice

This Agreement Period shall be from 12:01 a.m. January 1, 2026 to the end of the day of December 31, 2026.

Paid Claims shall be processed pursuant to the terms of this Agreement when incurred and paid as follows:

Incurred from 01/01/2026 through 12/31/2026 and

Paid from 01/01/2026 through 12/31/2026.

Anthem shall provide any offer to renew this Agreement at least 90 days prior to the end of an Agreement Period.

Section 2. Broker or Consultant Base Compensation

Not applicable

Section 3. Administrative Services Fees

Change to Administrative Services Fees. In addition to the provisions in Article 18(c), Anthem reserves the right to change the Administrative Services Fees provided in this Section 3 of Schedule A during the Agreement Period based upon the occurrence of any of the following events:

- Employer's enrollment is not within +/-10% of Subscribers;
- Employer moves any of the Plan benefits administered under this Agreement to another administrator or to a public or private exchange;
- A material reduction in Provider billed or published charges that results in a decrease in Anthem's discount of 10% or more;
- A change in law or regulation that materially impacts underwriting assumptions made at the time of the offer or renewal.

If Employer terminates the Pharmacy Services Schedule with PBM at any time, then Anthem shall have the right to amend the Administrative Services Fees indicated in Section 3 of Schedule A of this Agreement.

A. Base Administrative Services Fee

Base Medical Administrative Fee:	$32.43 per Subscriber per month
Rx Rebate Offset Fee:	($34.98) per Subscriber per month
Total Base Admin Fee:	**$0.00 per Subscriber per month**

Article 3(a) Retroactivity.

Notwithstanding anything to the contrary in the Agreement, Anthem reserves the right to limit the effective date of retroactive enrollment to a date not earlier than 60 days prior to the date the notice is received and Anthem reserves the right to limit retroactive terminations to a maximum of 60 days prior to the date the notice is received. Anthem reserves the right to not process Claims for retroactive additions beyond 60 days and to not pursue recovery of Claims for retroactive terminations beyond 60 days. Additionally, Anthem is not required to initiate recovery services if the Provider agreement or any law or regulation precludes recovery. Anthem shall credit per Subscriber per month and per Member per month Administrative Services Fees for each retroactive deletion up to a maximum of 60 days and shall charge Administrative Services Fees for each retroactive addition up to a maximum of 60 days.

B. Health and Wellness Program Fees

Wellbeing Solutions ASO Core Foundational Program--Muskuloskeletal: $1.65 per Subscriber per month. These charges are included in are included in Paid Claims on the invoice and may accumulate towards aggregate stop loss purchased from Anthem.

Wellbeing Solutions ASO Core Foundational Programs—Oncology: $0.85 per Subscriber per month. These charges are included in are included in Paid Claims on the invoice and may accumulate towards aggregate stop loss purchased from Anthem.

Wellbeing Solutions ASO Core Foundational Programs—Behavior Health: $1.59 per Subscriber per month. These charges are included in are included in Paid Claims on the invoice and may accumulate towards aggregate stop loss purchased from Anthem.

Wellbeing Solutions ASO Core Foundational Program—Radiology: $2.78 per Subscriber per month. These charges are included in are included in Paid Claims on the invoice and may accumulate towards aggregate stop loss purchased from Anthem.

Wellbeing Solutions ASO Core Foundational Program—Care Support: $0.59 per Subscriber per month. These charges are included in are included in Paid Claims on the invoice, and may accumulate towards aggregate stop loss purchased from Anthem.

C. Other Fees or Credits

Fee for Subrogation Services. The charge to Employer is 25% of gross subrogation recovery.

Fee for Overpayment Identification, Prevention, and Claims Prepayment Analysis Activities. The charge to Employer is 25% of (i) the amount recovered from review of Claims and membership data and audits of Provider and vendor activity to identify overpayments and (ii) the difference between the amount Employer would have been charged absent prevention or prepayment analysis activities and the amount that was charged to Employer following performance of prevention or prepayment analysis activities. This includes, but is not limited to, COB, Host Blue activities, contract compliance, and eligibility. The fee for Overpayment Identification, Prevention, and Claims Prepayment Analysis Activities will not exceed $25,000.00 per Claim.

Fee for Independent Claims Review: $500.00 per independent review.

Fees and Costs for Independent Dispute Resolution. Notwithstanding anything to the contrary in the Agreement, Employer shall assume liability for payment of all fees and costs, including but not limited to arbitrator fees, charged to or paid by Anthem as part of independent dispute resolution processes.

Enhanced Personal Health Care Fee. A fee shall be charged for Anthem's oversight of Enhanced Personal Health Care with Providers or Vendors. Such fee shall be 25% of the per attributed Member per month amount charged to Employer for the Provider performance bonus portion of the Enhanced Personal Health Care program. These charges are included in Paid Claims on the invoice and may accumulate towards any stop loss policy amounts.

Discount Share. Employer agrees to pay an additional amount based on the difference between Billed Charges for Covered Services and the Negotiated Amount. The "Negotiated Amount" is the amount Anthem, an Anthem Affiliate and/or Host Blue is contractually obligated to pay a Network Provider under a negotiated reimbursement arrangement, before application of Member cost-share amounts, such as deductibles, copayments and coinsurance. Prescription Drug Claims, Payment Innovation Program payments and Claims paid on a capitated basis are all excluded from the fee calculation. In addition, Claims paid at the out-of-network level of benefits using the Traditional Network fee schedule are excluded from the fee calculation. The Discount Share is equal to: 1.0% per Claim. up to $5,000.00 per Claim These charges are included in Paid Claims as claim related charges on the invoice.

Non-Network Savings Fee. If Anthem or its Vendor negotiates with a non-Network Provider for Covered Services from the non-Network Provider, Employer will pay a fee equal to 50% of the difference between the non-Network Provider's Billed Charges and the amount Anthem uses to calculate Plan liability for the Covered Service (the "Plan Liability Amount"). In the case of facility-based Provider Claims, Plan Liability Amount will be based on the negotiated rate; if negotiations are not successful, the Plan Liability Amount shall be determined using a pricing tool. Fees paid to Anthem for Claims priced through such tool will not exceed $25,000 per Claim. In the case of professional Provider Claims, Plan Liability Amount will be based upon the negotiated rate obtained by Anthem or its Vendor, if applicable (in the absence of successfully negotiated Claims, there will be no fee charged as the amount will be determined by the local Blue plan). These Claims will not be included in any Performance Guarantee calculations.

Unidentified Recoveries. Anthem shall retain any funds received through recovery processes that are paid to Anthem and, following good faith and reasonable efforts, cannot be tied to a specific Employer or Member.

Plan Program Credit. Anthem will provide a Plan Program Credit in the amount of $25,000.00. The Plan Program Credit only applies to expenses that are incurred and credited from January 01, 2026 through December 31, 2026 and, subject to Anthem approval, may be applied towards any combination of the following:

- Anthem health and wellness programs

The Plan Program Credit does not apply towards third party health and wellness programs, personnel costs, consultant expenses and fees, commissions, travel, office equipment and supplies, cash incentives, and programming expenses. Anthem may pay a third party directly for approved Plan Program Credit amounts upon written direction from Employer. The Plan Program Credit shall be made available according to the following schedule: twenty five thousand dollars ($25,000.00) on 01/01/2026, fifteen thousand dollars ($15,000.00) on 01/01/2027, and fifteen thousand dollars ($15,000.00) on 01/01/2028. Multi-Year Rate Period is defined as the period of time in Schedule A Section 3 in which the Base Administrative Services Fee applies upon offer and acceptance of renewal.

In the event that Employer terminates this Agreement prior to December 31, 2026 for any reason other than Anthem's failure to comply with a material duty or obligation related to the administration of Plan benefits under this Agreement, Plan Program Credits shall be forfeited and Employer shall reimburse Anthem for Plan Program Credit amounts within 30 days of the termination of this Agreement.

Fee for Ad Hoc Reports. Anthem shall provide, on an annual basis, up to 20 hours of time needed to generate custom or ad hoc reports at no additional charge. The charge to Employer beyond 20 hours per year is $150.00 per hour for time needed to generate custom or ad hoc reports.

Fee for Article 11(e) Data Audits. $150.00 per hour. Maximum of 250 Claims.

Fee for Electronic Data Feeds to Plan Contractors. Anthem shall provide electronic data Feeds on an annual basis to Plan Contractors as follows:

Standard Monthly Feeds. 12 Feeds are included in the Base Administrative Services Fee, $1,000.00 per month for each additional Feed

For the purposes of this provision, Feed is defined as each instance in which a data transmission is sent during the year.

Transitional Allowance:

The Parties understand that Employer may incur certain administrative, internal and external costs in transitioning its health benefit plan to Anthem. Employer remains solely and fully responsible for such expenses. However, in recognition (but not necessarily reimbursement) of such costs, Anthem agrees to pay or otherwise credit Employer with a one-time administrative expense allowance ("Allowance"), in the amount of: seventy five thousand dollars ($75,000.00)

The Parties further agree and acknowledge that the Allowance shall be paid or credited upon Anthem's receipt of Employer's full payment of the first month of Administrative Service Fees under this Agreement. Although the full amount of the Allowance is paid or credited upon Anthem's receipt of such first full payment, the Parties agree that the Allowance shall be deemed earned and vested on a pro rata monthly basis over the course of the first Agreement Period. Employer acknowledges and agrees that Anthem will report the payment or credit of the Allowance where required by law to do so. In the event that Employer terminates the Agreement prior to the end of the Agreement Period, the Allowance amount shall be reduced and, following invoice receipt, Employer shall reimburse Anthem for any applicable excess Allowance amount within 30 days of the termination of the Agreement. The reduced Allowance amount will be based on the prorated portion of the total Allowance amount which will be calculated by dividing the number of months from the beginning of the Agreement Period in Schedule A through the effective date of termination by the total number of months in the full Agreement Period in Schedule A and by then multiplying that result by the total Allowance amount.

Employee Assistance Program ("EAP")

Eligible Employee Fee.	$0.48 per Eligible Employee per month
*Fees below apply for Basic Services:	
Program Orientation, Training, or Health Benefit Fairs.	per hour, per presenter (onsite or virtual)
*Critical Incident Response.	per hour, per EAP Practitioner (onsite or virtual)

Section 4. Paid Claims, Billing Cycle and Payment Method

A. Paid Claims

Paid Claims are described in Article 1-Paid Claims Definition of the Agreement.

B. Billing Cycle

Weekly

Anthem shall notify Employer of the amount due to Anthem as a result of Claims processed and paid by Anthem according to the billing cycle described above. The actual date of notification of Paid Claims and the Invoice Due Date will be determined according to Anthem's regular business practices and systems capabilities.

C. Payment Method

Section 5. Administrative Services Fees Billing Cycle and Payment Method

A. Billing Cycle

Monthly List Bill (pay as billed)

Anthem shall notify Employer of the amount due to Anthem pursuant to Section 3 of Schedule A according to the billing cycle described above. The actual date of notification of amounts due and the Invoice Due Date will be determined according to Anthem's regular business practices and systems capabilities.

B. Payment Method

Section 6. Claims Runout Services

A. Claims Runout Period

Medical:

Claims Runout Period shall be for the 12 months following the date of termination of this Agreement.

B. Claims Runout Administrative Services Fee

Medical:

The fee for Claims Runout Services will be equal to 9% of Paid Claims. Fees in Sections 3(B), 3(C), and 7 of this Schedule A that (i) are associated with Claims processed or reviewed during the Claims Runout Period including without limitation subrogation fees, Claims prepayment analysis fees, recovery fees, discount share fees, network access fees; or (ii) apply to the Agreement Period but were not billed during the Agreement Period, will be billed and payable during the Claims Runout Period. Payment is due to Anthem by the Invoice Due Date.

Section 7. Inter-Plan Arrangements

Certain fees and compensation are charged each time a Claim is processed through the BlueCard Program and include, but are not limited to, Access Fees, AEA Fees, CFA Fees and ITS Transaction Fees. Other Inter-Plan Arrangement related fees that Anthem may charge include, but are not limited to, fees for Blue Cross Blue Shield Global Core® Program services. These fees may be separately billed or included in Paid Claims. The extent to which these fees and compensation are (i) included in the Base Administrative Services Fee; or (ii) included in Paid Claims or separately billed to Employer is as follows:

BlueCard Fees

Access Fees and AEA Fees will be included in the Base Administrative Services Fees for Claims incurred in the Anthem Service Areas for the following states: California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin.

Access Fees (Network Provider Claims only):

• 3.31% for fewer than 1,000 PPO traditional enrolled Blue Subscribers of network savings, capped at $2,000.00 per Claim.

Administrative Expense Allowance Fees ("AEA") (Network Provider and Non-Network Provider Claims):

• Network Provider - $5.00 per professional Claim and $11.00 per institutional Claim for fewer than 1,000 PPO or traditional enrolled Blue Subscribers.

• Non-Network Provider - $3.00 per Claim.

Central Financial Agency Fee ("CFA") (Network Provider, Non-Network Provider and Blue Cross Blue Shield Global Core Claims):

• $0.35 per payment notice.

ITS Transaction Fee ("ITS") (Network Provider, Non-Network Provider and Blue Cross Blue Shield Global Core Program Claims):

• $0.05 per transaction.

Blue Cross Blue Shield Global Core Fees

Administrative Expense Allowance Fee:

• $4.35 per Member-submitted Claim;

• $5.50 per professional Claim; and

• $18.55 per institutional Claim.

All other fees associated with the Blue Cross Blue Shield Global Core program, except the CFA and ITS Fees described above, are included in the Base Administrative Services Fee.

Section 8. Other Amendments. The Administrative Services Agreement is otherwise amended as follows:

Not applicable

SCHEDULE B
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
City of Littleton

This Schedule B shall govern the Agreement Period from January 1, 2026 through December 31, 2026. For purposes of this Agreement Period, this Schedule B shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms of the Agreement including any prior Schedules and this Schedule B, the terms of this Schedule B shall control.

The following is a list of services that Anthem will provide under this Agreement for the Base Administrative Services Fee listed in Section 3(A) of Schedule A. These services will be furnished to Employer in a manner consistent with Anthem's standard policies and procedures for self-funded plans.

Anthem may also offer additional, optional services to Employer, and such services, whether or not purchased by Employer, are not included in the services set forth below in this Schedule B. By way of example and not limitation, Anthem may offer certain optional programs that include utilization management activities. In such event, the services associated with those programs are not included in the services described below. Services under Article 13 will only be pursued or performed for Claims associated with these programs or that would have been impacted by these programs if the programs are purchased by Employer. If Employer has purchased such services, those services and any additional fees are also listed in Schedule A.

SERVICES INCLUDED IN THE BASE ADMINISTRATIVE SERVICES FEE IN SECTION 3A OF SCHEDULE A

Management Services

Anthem's benefits and administration as described in this paragraph:

- Anthem definitions, and exclusions
- Anthem complaint and appeals process (One mandatory level of appeal, one voluntary level of appeal)
- Claims incurred and paid as provided in Schedule A, excluding activities related to Claim recovery
- Accumulation toward plan maximums beginning at zero on effective date
- Anthem Claim forms
- ID card
- Explanation of Benefits (Non-customized)

• Acceptance of electronic submission of eligibility information in HIPAA-compliant format
• Account reporting - standard data reports
• Standard billing and banking services
• Plan Design consultation
• Employer eServices
  - Add and delete Members
  - Download administrative forms
  - View Member Benefits and request ID cards
  - View eligibility
  - View Claim status and detail
• Responsible Reporting Entity for the Plan
• Information for preparation of SBC

Claims and Customer Services

- Claims processing services
- Medicare crossover processing
- Employer customer service, standard business hours
- Member customer service, standard business hours
- 1099s prepared and delivered to Providers
- Residency-based assessments and/or surcharges and other legislative reporting requirements
- Member eServices
- Member identity theft and credit monitoring and identity repair

Care Management

- Health Care Management
  - Referrals
  - Utilization management
  - Case management
  - Anthem Medical Policy
- SpecialOffers
- Member Digital Tools

Networks

- Network Management
- Online Provider directory

Other Services Required by Federal Law not Otherwise Specified in the Agreement (as of the applicable effective date)

- For Claims that qualify as no surprises Claims, Anthem shall calculate and apply the Member's cost share at the in-network benefit level using the qualifying payment amount. Anthem shall post a disclosure of the patient protections against balance billing on www.anthem.com and shall include applicable language in Claim denial notices and explanations of benefits.
- Prepare advanced explanations of benefits to Members after receiving a notice of scheduled services from a Provider
- Provide cost transparency tool/self-service tool access
- Provide for continuity of care administration for Provider termination from the network
- Provide air ambulance Provider reporting
- Provide aggregated reporting as required under Section 204 of the CAA for the services that Anthem administers under the Agreement. This reporting does not include the D1 Premium and Life Years Report.
- Anthem represents that it is administering its Provider agreements consistent with the requirements set forth in Section 201 of the CAA. Anthem will provide a statement of compliance to Employer pertaining to Section 201 of the CAA on an annual basis.
- Upon request, Anthem will provide the non-quantitative treatment limitation analysis for the standard services that Anthem provides under the Agreement. Anthem will also provide reasonable assistance to Employer in the event of a regulatory audit for compliance with the Mental Health Parity and Addiction Equity Act.
- Post machine readable files on a monthly basis for the services Anthem administers for the Plan on www.anthem.com

SCHEDULE C
TO THE
ADMINISTRATIVE SERVICES AGREEMENT
WITH
City of Littleton

This Schedule C provides certain guarantees pertaining to Anthem's performance under the Agreement between the Parties ("Performance Guarantees") and shall be effective for the period from January 1, 2026 through December 31, 2026 (the "Performance Period"). Descriptions of the terms of each Performance Guarantee applicable to the Parties are set forth in the Attachments (the "Attachments") to this Schedule C and made a part of this Schedule C. This Schedule shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms of the Agreement including any prior Schedules and this Schedule C, the terms of this Schedule C shall control. If there are any inconsistencies between the terms contained in this Schedule, and the terms contained in any of the Attachments to this Schedule C, the terms of the Attachments to this Schedule C shall control unless otherwise specified.

Section 1. General Conditions

A. The Performance Guarantees described in the Attachments to this Schedule C shall be in effect only for the Performance Period indicated above, unless specifically indicated otherwise in the Attachments. Each Performance Guarantee shall specify a/an:

1. Performance Category. The term Performance Category describes the general type of Performance Guarantee.

2. Reporting Period. The term Reporting Period refers to how often Anthem will report on its performance under a Performance Guarantee.

3. Measurement Period. The term Measurement Period is the period of time under which Anthem's performance is measured, which may be the same as or differ from the period of time equal to the Performance Period.

4. Penalty Calculation. The term Penalty Calculation generally refers to how Anthem's payment will be calculated, in the event Anthem does not meet the target(s) specified under the Performance Guarantee.

5. Amount at Risk. The term Amount at Risk means the amount Anthem may pay if it fails to meet the target(s) specified under the Performance Guarantee.

B. Anthem shall conduct an analysis of the data necessary to calculate any one of the Performance Guarantees within the timeframes provided in the Attachments to this Schedule C. In addition, any calculation of Performance Guarantees, reports provided, or analysis performed by Anthem shall be based on Anthem's then current measurement and calculation methodology, which shall be available to Employer upon request.

C. Any audits performed by Anthem to test compliance with any of the Performance Guarantees shall be based on a statistically valid sample size with a 95% confidence level.

D. If the Parties do not have an executed Agreement, Anthem shall have no obligation to make payment under these Performance Guarantees.

E. Unless otherwise specified in the Attachments to this Schedule C, the measurement of the Performance Guarantee shall be based on data that is maintained and stored by Anthem or its Vendors.

F. If Employer terminates the Agreement between the Parties prior to the end of the Performance Period, or if the Agreement is terminated for non-payment, then Employer shall forfeit any right to collect any further payments under any outstanding Performance Guarantees, whether such Performance Guarantees are for a prior or current Measurement Period or Performance Period.

G. Anthem reserves the right to make changes to any of the Performance Guarantees provided in the Attachments to this Schedule C upon the occurrence, in Anthem's determination, of:

1. a change to the Plan benefits or the administration of the Plan initiated by Employer that results in a substantial change in the services to be performed by Anthem or the measurement of a Performance Guarantee;

2. an increase or decrease of 10% or more of the number of Members that were enrolled for coverage on the latter of the effective date or renewal date of this Agreement;

3. a change in law or regulation that materially impacts underwriting assumptions made at the time of offering such Performance Guarantees.

Should there be a change in occurrence as indicated above and these changes negatively impact Anthem's ability to meet the Performance Guarantees, upon prior notice to Employer, Anthem shall have the right to modify the Performance Guarantees contained in the Attachments.

H. For the purposes of calculating compliance with the Performance Guarantees contained in the Attachments to this Schedule C, if a delay in performance of, or inability to perform, a service underlying any of the Performance Guarantees is due to circumstances which are beyond the control of Anthem, or its Vendors, including but not limited to any act of God, civil riot, floods, fire, acts of terrorists, acts of war or power outage, such delayed or non-performed service will not count towards the measurement of the applicable Performance Guarantee.

I. Some Performance Guarantees measure and compare year to year performance. The term Baseline Period refers to the equivalent time period preceding the Measurement Period. Anthem will require specified historical Claims and utilization data to establish the Baseline Period for the first year of a Performance Guarantee utilizing a Baseline Period.

J. As determined by Anthem, Performance Guarantees may be measured using either aggregated data or Employer-specific Data. The term Employer-specific Data means the data associated with Employer's Plan that has not been aggregated with other employer data. Performance Guarantees will specify if Employer-specific Data shall be used for purposes of measuring performance under the Performance Guarantee.

K. If any Performance Guarantees are tied to a particular program and its components, such Performance Guarantees are only valid if the Employer participates in the program and its components for the entirety of the Measurement Period associated with the Performance Guarantee.

L. All Performance Guarantees in which Anthem will make outbound calls or will reach out through email or other means to members will exclude members who Anthem cannot reach due to incorrect or invalid telephone numbers, including numbers where permission is required by law but not provided, or those members who have requested that Anthem not contact them.

M. All Performance Guarantees may be revisited and may potentially be impacted due to a cause beyond the reasonable control of a Party such as a pandemic (an outbreak of disease that affects an exceptionally high proportion of members) being declared by the Centers for Disease Control or if a Force Majeure event (meaning an act of God, civil or military disruption, terrorism, fire, strike, flood, riot or war) occurs during the Measurement or Baseline Period that impacts a meaningful portion of the Employer population.

Section 2. Payment

A. If Anthem fails to meet any of the obligations specifically described in a Performance Guarantee, Anthem shall pay Employer the amount set forth in the Attachment described under the Performance Guarantee. Payment shall be in the form of a credit on Employer's invoice for Administrative Services Fees, which will occur annually unless otherwise stated in the Performance Guarantee.

B. Notwithstanding the above, Anthem has the right to offset any amounts owed to Employer under any of the Performance Guarantees contained in the Attachments to this Schedule C against any amounts owed by Employer to Anthem under: (1) any Performance Guarantees contained in the Attachments to this Schedule C; (2) the Agreement; or, (3) any applicable Stop Loss Policy

C. Notwithstanding the foregoing, Anthem's obligation to make payment under the Performance Guarantees is conditioned upon Employer's timely performance of its obligations provided in the Agreement, in this Schedule C, and the Attachments, including providing Anthem with the information or data required by Anthem in the Attachments. Anthem shall not be obligated to make payment under a Performance Guarantee if Employer or Employer's vendor's action or inaction adversely impacts Anthem's ability to meet any of its obligations provided in the Attachments related to such Performance Guarantee, which expressly includes but is not limited to Employer or its vendor's failure to timely provide Anthem with accurate and complete data or information in the form and format expressly required by Anthem.

D. Where the Amount at Risk for a Performance Guarantee is on a percentage of a Per Subscriber Per Month (PSPM) fee basis, the Guarantee will be calculated by multiplying the PSPM amount by the actual annual enrollment during the Measurement Period.

Section 3. Performance Guarantee Amounts at Risk

Amount at Risk

The total amount at risk for the below performance guarantees between Anthem and City of Littleton shall not exceed the following:

- Operations Guarantees: 20.0% of Base Medical Administration fees

Confirmation of all applicable fees for the performance guarantees will be reflected in Employer's Schedule C.

Maximum Amount Payable

The maximum amount payable under all guarantees between Anthem and City of Littleton shall not exceed 20.0% of the Base Medical Administration fees . The Maximum Amount Payable provisions above do not apply to Pharmacy-related Performance Guarantees.

ATTACHMENT 1 TO SCHEDULE C

Performance Guarantees

TO ADMINISTRATIVE SERVICES AGREEMENT

WITH

City of Littleton

Operations Performance Guarantees

This Attachment is made part of Schedule C and will be effective for (each year in) the Performance Period from January 01, 2026 through December 31, 2026. This Attachment is intended to supplement and amend the Agreement between the Parties.

Performance Category	Year 1
Implementation	2.0% of Base Admin. Services Fees
Claims Timeliness - (14 Calendar Days)	2.0% of Base Admin. Services Fees
Claim Timeliness - (30 Calendar Days)	2.0% of Base Admin. Services Fees
Claims Financial Accuracy	2.0% of Base Admin. Services Fees
Claims Accuracy	2.0% of Base Admin. Services Fees
Open Enrollment ID Card Issuance	1.5% of Base Admin. Services Fees
Processing of Ongoing Eligibility Information	1.5% of Base Admin. Services Fees
Ongoing ID Cards Issuance	2.0% of Base Admin. Services Fees
Average Speed to Answer	1.5% of Base Admin. Services Fees
Call Abandonment Rate	1.5% of Base Admin. Services Fees
Account Management Satisfaction	2.0% of Base Admin. Services Fees
Total Amount At Risk – Operations	**20.0%**

Additional Terms and Conditions:

- For purposes of imposing penalties, measurement shall not begin until the start of the fourth month of the initial Agreement period for the following measures: Claims Timeliness, Claims Financial Accuracy, Claims Accuracy, Average Speed of Answer, Call Abandonment Rate, and First Call Resolution.

- Performance will be based on the results of a designated service team/business unit assigned to City of Littleton unless the guarantee is noted as measured with Employer-specific Data.

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
Implementation	Year 1: 2.0% of Base Admin. Services Fees	A minimum of 95% of all tasks will be completed by the dates specified in the implementation plan agreed to by the Parties. The implementation plan will be developed by Anthem and will contain tasks to be completed by Employer and/or Anthem and a timeframe for completion of each task. The implementation plan will also contain Measurement Periods specific to each task. Anthem's payment under this Guarantee is conditioned upon Employer's completion of all designated tasks by the dates specified in the implementation plan. This will be measured with Employer-specific Data.	**Result** / **Penalty** 95.0% or Greater: None 91.0% to 94.9%: 25% 89.0% to 90.9%: 50% 85.0% to 88.9%: 75% Less than 85.0%: 100%	**Measurement Period** Defined in Implementation Plan **Reporting Period** 60 calendar days following the end of the implementation period
Claims Timeliness (14 Calendar Days)	Year 1: 2.0% of Base Admin. Services Fees	A minimum of 90% of Non-investigated medical Claims will be processed timely. Non-investigated Claims are defined as medical Claims that process through the system without the need to obtain additional information from the Provider, Subscriber or other external sources. Processed Timely is defined as Non-investigated medical Claims that have been adjudicated within 14 calendar days of receipt. This Guarantee will be calculated based on the number of Non-investigated Claims that Processed Timely divided by the total number of Non-investigated Claims. The calculation of this Guarantee does not include Claim adjustments. The calculation of this Guarantee also excludes in any quarter, Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented. This will be measured with Employer-specific Data.	**Result** / **Penalty** 90.0% or Greater: None 88.0% to 89.9%: 25% 86.0% to 87.9%: 50% 85.0% to 85.9%: 75% Less than 85.0%: 100%	**Measurement Period** Annual **Reporting Period** Annual

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
Claim Timeliness (30 Calendar Days)	Year 1: 2.0% of Base Admin. Services Fees	A minimum of 98% of Non-investigated medical Claims will be processed timely. Non-investigated medical Claims are defined as Claims that process through the system without the need to obtain additional information from the Provider, Subscriber, or other external sources. Processed Timely is defined as Non-investigated medical Claims that have been adjudicated within 30 calendar days of receipt. This Guarantee will be calculated based on the number of Non-investigated Claims that Processed Timely divided by the total number of Non-investigated Claims. The calculation of this Guarantee does not include Claim adjustments. The calculation of this Guarantee also excludes in any quarter, Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented. This will be measured with Employer-specific Data.	**Result** / **Penalty** 98.0% or Greater — None 96.0% to 97.9% — 25% 94.0% to 95.9% — 50% 92.0% to 93.9% — 75% Less than 92.0% — 100%	**Measurement Period** Annual **Reporting Period** Annual
Claims Financial Accuracy	Year 1: 2.0% of Base Admin. Services Fees	A minimum of 99% of medical Claim dollars will be processed accurately. This Guarantee will be calculated based on the total dollar amount of audited medical Claims paid correctly divided by the total dollar amount of audited medical Paid Claims. The calculation of this Guarantee includes both underpayments and overpayments. The calculation of this Guarantee does not include Claim adjustments or Claims in any quarter in which an Employer requests changes to Plan benefits, until all such changes have been implemented.	**Result** / **Penalty** 99.0% or Greater — None 98.0% to 98.9% — 25% 97.0% to 97.9% — 50% 96.0% to 96.9% — 75% Less than 96.0% — 100%	**Measurement Period** Annual **Reporting Period** Annual
Claims Accuracy	Year 1: 2.0% of Base Admin. Services Fees	A minimum of 97% of medical Claims will be paid or denied correctly. This Guarantee will be calculated based on the number of audited medical Claims paid and denied correctly divided by the total number of audited medical Claims paid and denied. The calculation of this Guarantee excludes in any quarter Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented.	**Result** / **Penalty** 97.0% or Greater — None 96.0% to 96.9% — 25% 95.0% to 95.9% — 50% 94.0% to 94.9% — 75% Less than 94.0% — 100%	**Measurement Period** Annual **Reporting Period** Annual

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
Open Enrollment ID Card Issuance	Year 1: 1.5% of Base Admin. Services Fees	100% of Subscriber digital ID cards will be available or Member physical ID cards will be mailed to Open Enrollment participants no later than the Employer's effective date provided that Anthem receives an Accurate Eligibility File. An Accurate Eligibility File is defined as: (1) an electronic eligibility file formatted in a mutually agreed upon manner; (2) received by Anthem no later than 30 calendar days prior to the Employer's effective date; and, (3) contains an error rate of less than 1%. This Guarantee will be calculated based on the total number of Open Enrollment ID cards available to Subscribers or mailed to Members within the timeframe set forth above divided by the total number of Members eligible to receive Open Enrollment ID cards. This will be measured with Employer-specific Data.	**Result** / **Penalty** 100% — None 99.0% to 99.9% — $100 per ID Card not to exceed 25% of amount at risk for this measure 98.0% to 98.9% — 50% 97.0% to 97.9% — 75% Less than 97.0% — 100%	**Measurement Period** Employer's effective date **Reporting Period** 60 days following the Employer's effective date.
Processing of Ongoing Eligibility Information	Year 1: 1.5% of Base Admin. Services Fees	100% of Employer's ongoing electronic eligibility files will be processed timely. Timely Processing is defined as electronic eligibility files processed and updated on the eligibility database within 7 business days of receipt of an eligibility file. This Guarantee only applies to the processing of eligibility files submitted by Employer outside of an open enrollment period. This Guarantee does not apply to a defective eligibility file. A defective Eligibility File is defined as an eligibility file that has issues that prevent Anthem's processing of the file. Anthem's payment of this Guarantee is conditioned upon receipt of eligibility files in a format mutually agreed upon by the Parties. This Guarantee will be calculated by (1) dividing the total number of eligibility files processed within the timeframe set forth above by (2) the number of Employer's eligibility files processed. This will be measured with Employer-specific Data.	**Result** / **Penalty** 100% — None 98.0% to 99.9% — 25% 96.0% to 97.9% — 50% 94.0% to 95.9% — 75% Less than 94.0% — 100%	**Measurement Period** Annual **Reporting Period** Annual

Performance Category	Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period
Ongoing ID Cards Issuance	Year 1: 2.0% of Base Admin. Services Fees	A minimum of 99% of Subscriber digital ID cards will be available or Member physical ID cards will be mailed to Members within 10 business days of [Anthem's] processing of an Accurate Eligibility File. An Accurate Eligibility File is defined as: (1) an eligibility file formatted in a mutually agreed upon manner; (2) received by Anthem outside of an open enrollment period; and, (3) contains an error rate of less than 1%. This Guarantee will be calculated based on the total number of ongoing ID cards available to Subscribers or mailed to Members within the timeframe set forth above divided by the total number of Members eligible to receive ongoing ID cards. This will be measured with Employer-specific Data.	**Result**	**Penalty**	**Measurement Period** Annual **Reporting Period** Annual
			99.0% or Greater	None	
			98.0% to 98.9%	25%	
			97. 0% to 97.9%	50%	
			96.0% to 96.9%	75%	
			Less than 96.0%	100%	
Average Speed to Answer	Year 1: 1.5% of Base Admin. Services Fees	The average speed to answer (ASA) will be 45 seconds or less. ASA is defined as the average number of whole seconds members wait and/or are in the telephone system before receiving a response from a customer service representative (CSR) or an interactive voice response (IVR) unit. This Guarantee will be calculated based on the total number of calls received in the customer service telephone system.	**Result**	**Penalty**	**Measurement Period** Annual **Reporting Period** Annual
			45 seconds or less	None	
			46 to 48 seconds	25%	
			49 to 51 seconds	50%	
			52 to 54 seconds	75%	
			55 or more seconds	100%	
Call Abandonment Rate	Year 1: 1.5% of Base Admin. Services Fees	A maximum of 5.0% of member calls will be abandoned. Abandoned Calls are defined as member calls that are waiting for a customer service representative (CSR), but are abandoned before connecting with a CSR. This Guarantee will be calculated based on the number of calls abandoned divided by the total number of calls received in the customer service telephone system. Calls that are abandoned in less than 5 seconds will not be included in this calculation.	**Result**	**Penalty**	**Measurement Period** Annual **Reporting Period** Annual
			5.0% or Less	None	
			5.01% to 5.40%	25%	
			5.41% to 5.70%	50%	
			5.71% to 5.99%	75%	
			6.0% or Greater	100%	

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
Account Management Satisfaction	Year 1: 2.0% of Base Admin. Services Fees	A minimum average score of 3.0 will be attained on the Account Management Satisfaction Survey (AMSS). A minimum of 3 responses per Employer to the AMSS is required to base the score on Employer-specific responses only. If 3 responses are received from the Employer, an average score is calculated by adding the scores from each respondent divided by the total number of Employer respondents. If fewer than 3 responses are received, the score will be calculated as follows: 2 Employer responses: 2/3 of the score will be based on Employer-specific AMSS results and 1/3 of the score will be based on the aggregate score of all AMSS results received by the Account Management Team. 1 Employer- response: 1/3 of the score will be based on Employer- specific AMSS results and 2/3 of the score will be based on the aggregate score of all AMSS results received by the Account Management Team. 0 Employer responses: The score will be based on the aggregate score of all AMSS results received by the Account Management Team.	**Result** / **Penalty** 3.0 or higher — None 2.5 to 2.9 — 25% 2.0 to 2.4 — 50% Less than 2.0 — 100%	**Measurement Period** Annual **Reporting Period** Annual

PHARMACY BENEFITS ADMINISTRATIVE SERVICES SCHEDULE
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
City of Littleton

This Pharmacy Benefits Administrative Services Schedule ("Pharmacy Services Schedule") is by and between Employer and CarelonRx, Inc., a Rocky Mountain Hospital and Medical Service, Inc. dba Anthem Blue Cross and Blue Shield Affiliate that will be referenced as the pharmacy benefits manager ("PBM") for the purposes of this Pharmacy Services Schedule. The Pharmacy Services Schedule supplements and amends the Agreement between the Parties and is effective from 1/1/2026 through 12/31/2028 (which, for the purposes of this Pharmacy Services Schedule and its Exhibits, is defined as the "Agreement Period"). The description and applicable fees for the Pharmacy Services provided are set forth in the Exhibits to this Pharmacy Services Schedule.

A. **Definitions**. The following definitions apply to this Pharmacy Services Schedule. Terms not otherwise defined in this Pharmacy Services Schedule shall have the same meaning as such term is otherwise defined in the Agreement.

- **340B Claims.** Prescription Drug Claims identified by the submission of "20" in any of the Submission Clarification Code fields, or a claim submitted by a 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. In addition, 340B Claims may be separately identified as such by the manufacturers. PBM reviews post-adjudication files provided by pharmaceutical manufacturers to exclude additional 340B Claims for Prescription Drug Rebates.
- **Acute/Short-Term Claim.** A Prescription Drug Claim for drugs prescribed for limited-duration use, generally not exceeding a 30 day supply, to treat acute or episodic conditions.
- **Affordable Care Act (ACA) Claims.** Prescription Drugs required to be covered with no Member cost share for preventive health services under the Patient Protection and Affordable Care Act and implementing regulations.
- **Annualized Adjusted Prescription Drug Claims.** The annualized sum of the total number of: (i) retail Prescription Drug Claims with less than 84 days' supply; (ii) retail Prescription Drug Claims with greater than or equal to 84 days' supply multiplied by a factor of 3; (iii) mail order Prescription Drug Claims multiplied by a factor of 3; and (iv) Specialty Prescription Drug Claims.
- **Authorized Generics.** A Prescription Drug that was originally marketed, licensed and/or sold by the innovator drug manufacturer, but may be either produced, relabeled, marketed and/or sold under a generic name by either the innovator or another manufacturer or distributor with the innovator drug manufacturers' permission. This includes, but is not limited to, any medications or products classified as an Authorized Generic in the FDA database.
- **Average Wholesale Price (AWP).** The average wholesale price of a Prescription Drug at the date and time the Prescription Drug is dispensed by the Network Pharmacy as established and reported by the Pricing Source. The AWP of a Prescription Drug shall be the AWP as reported by the Pricing Source and updated daily for the 11-digit NDC, drug specific, quantity appropriate actual package size dispensed as reported by the Network Pharmacy.
- **Brand MAC.** A multi-source Brand Drug that is included on PBM's Maximum Allowable Cost ("MAC") list and paid at the MAC cost basis.
- **Brand Name Prescription Drug** or **Brand Drug.** A Prescription Drug that is not a Generic Drug. An FDA approved drug, or a drug that is designated by FDA a DESI (Drug Efficacy Study Implementation) drug, or product, which is manufactured and distributed by an innovator drug company, or its licensee, set forth in Medi-Span's National Drug Data File (MS) as a brand drug identified by all of the products meeting at least one of the following criteria: (i) Brand Name code of "T" and Multisource Code "M"; (ii) Brand Name code of "B" or "T" and Multisource Code of "N"; (iii) Brand Name code of "B" or "T" and Multisource Code "O" and a DAW code of 0, 1, 2, 7, 8, or 9. For the avoidance of doubt, Brand Drugs shall also include, brand name vaccines, supplies, medical devices, kits, diabetic supplies, OTCs and test strips.
- **Branded Generic Claims.** Multi-source Brand Drugs billed to the Employer at the Generic Drug cost.
- **COBRA Claims.** Any claims for services rendered to a Member during the period in which the Member

elected COBRA continuation coverage pursuant to Section 4980B of the Internal Revenue Code of 1986, as amended, and the applicable provisions of ERISA or similar state laws providing for continuation of coverage.

- **Compound Drug.** A drug that is a mixture of two or more ingredients when at least one of the ingredients in the preparation is an FDA-approved Prescription Drug, excluding the addition of only water or flavoring to any preparation.
- **Contract Year.** Each 12-month period beginning on the effective date until this Pharmacy Services Schedule is terminated.
- **Coordination of Benefits or COB Claim(s).** A Claim where coordination with more than one payer on a Claim is required. Payers can include, but are not limited to, health insurance programs, policies, or other form of coverage or payment, including governmental or non-governmental coverage, coupons, copay or other financial assistance or other payments of any nature regardless of the order of payment.
- **Covered Prescription Services.** A service that is Prescription Drugs or other pharmaceutical products, services or supplies dispensed by a pharmacy to a Member for which coverage is provided in accordance with the Member's Benefits Booklet.
- **Dispense As Written Claims With Code 1.** Claims where a Brand Drug was dispensed when a Generic Drug is available, because substitution was not allowed by the Provider.
- **Dispense As Written Claims With Code 2.** Claims where a Brand Drug was dispensed when a Generic Drug is available, because the Member requested the Brand Drug.
- **Dispense As Written Claims With Code 3.** Claims where a Brand Drug was dispensed when a Generic Drug is available, because the pharmacist selected the Brand Drug.
- **Dispense As Written Claims With Code 4.** Claims where a Brand Drug was dispensed when a Generic Drug exists, because the Generic Drug was not in stock.
- **Dispense As Written Claims With Code 5.** Claims where a Brand Drug was dispensed when a Generic Drug is available, because the pharmacy dispensed the Brand Drug at the Generic Drug cost (also known as “House Generic Claims”).
- **Dispense As Written Claims With Code 6.** Claims where a Brand Drug was dispensed when a Generic Drug is available, because of an override.
- **Dispense As Written Claims With Code 7.** Claims where a Brand Drug was dispensed when a Generic Drug is available, because the Brand Drug is mandated by state and federal laws and regulations.
- **Dispense As Written Claims With Code 8.** Claims where a Brand Drug was dispensed when a Generic Drug exists, because the Generic Drug is not available in the marketplace.
- **Dispense As Written Claims With Code 9.** Claims where a Brand Drug was dispensed when a Generic Drug is available, because of other non-specified reason.
- **Dispensing Fee.** The amount paid for professional services rendered by a licensed pharmacist in dispensing Prescription Drugs.
- **Drug Rebates.** Drug Rebates as referenced herein shall include Medical Drug Rebates and/or Prescription Drug Rebates.
- **Formulary.** The list of Prescription Drugs or products (which may include over-the-counter drugs, supplies, devices, equipment, and other items such as disposable insulin syringes, and other diabetic supplies) developed, published, and revised from time to time by PBM.
- **Formulary Exception Claims.** Prescription Drugs Claims that are approved via an exception process by PBM or Employer.

- **Generic Prescription Drug** or **Generic Drug.** An FDA approved drug, or a drug that is designated by FDA a DESI (Drug Efficacy Study Implementation) drug, or product, that is therapeutically equivalent to other pharmaceutically equivalent products, as set forth in Medi-Span's National Drug Data File (MS) as a generic drug identified by all products meeting at least one of the following criteria: (i) Brand Name code of "G" for all Multisource Codes (M, N, O, and Y); (ii) Multisource Code of "Y"; (iii) Multisource Code of "M" with a Brand Drug Code of "B" (Authorized Generic); (iv) "O" with a DAW code of 3, 4, or 6; (v) Multisource Codes (M, N, O, and Y) with a DAW code of 5 (House Generic). For the avoidance of doubt, Generic Drugs shall also include, generic vaccines, supplies, medical devices, kits, diabetic supplies, OTCs and test strips.
- **Home Infusion Pharmacy Claims.** A specialized type of pharmacy that prepares and provides medications and related supplies for patients to receive intravenous, subcutaneous, or other infusions in the home or alternate sites rather than in a hospital or clinic; identified in NCPDP DataQ with Dispenser Type Code 06 (Home Infusion Therapy Provider).
- **Indian Health Pharmacy Claims.** A pharmacy operated by (i) the Indian Health Service, (ii) an Indian tribe or tribal organization, or (iii) an urban Indian organization, each as defined in the Indian Health Care Improvement Act, 25 U.S.C. § 1603; identified in NCPDP DataQ with Dispenser Type Code 08 (Indian Health Service/Tribal/Urban Indian (I/T/U) Pharmacy).
- **Ingredient Cost.** The component of the prescription price that represents the charge for the ordered Prescription Drug product, supply, or other product (excluding any Dispensing Fee, administrative fee, or taxes).
- **Long-Term Care Pharmacy Claims.** A pharmacy that dispenses medications and related services to patients residing in long-term care facilities (e.g., skilled nursing facilities, intermediate care facilities, assisted living, group homes, hospice, and other congregate-living arrangements); identified in NCPDP DataQ with Dispenser Type Code 04 (Long-Term Care Pharmacy).
- **Maximum Allowable Cost or MAC.** The unit price applicable to a Covered Prescription Service as set forth on PBM's MAC list.
- **MAC List.** A list developed, maintained, and updated from time to time by PBM identifying Covered Prescription Services with a Maximum Allowable Cost or MAC unit prices.
- **Mail Order Pharmacy.** A Network Pharmacy that provides Covered Prescription Services to Members through PBM's mail order network via mailing or shipping utilizing the United States Postal Service and/or other common shipping carrier, including FedEx and/or United Parcel Service.
- **Manufacturer Administrative Fees.** Amounts received by PBM from manufacturers for administering, allocating, and collecting Prescription Drug Rebates that are attributable to Prescription Drugs.
- **Medical Drug Rebates.** Rebates Anthem and/or PBM receives directly from pharmaceutical manufacturers associated with utilization that is contingent upon and related directly to a Member's use of a Prescription Drug administered by Anthem and covered under the medical benefit portion of the Plan(s). Medical Drug Rebates do not include any discount, price concession, or other direct or indirect remuneration Anthem and/or PBM receives for the provision of any products or services to pharmaceutical manufacturers.
- **Military/Department of Veterans Affairs Pharmacy Claims.** Any pharmacy under the jurisdiction of the U.S. Department of Veterans Affairs (Dispenser Type Code 09) or a Department of Defense/U.S. Coast Guard entity serving Uniformed Services beneficiaries (Dispenser Type Code 17).
- **Network Pharmacy or Network Pharmacies.** A Mail Order Pharmacy, Retail Pharmacy, Specialty Pharmacy or other facility that is duly licensed to operate as a pharmacy at its location and to dispense Covered Prescription Services to Members and has entered into a participating pharmacy Agreement with PBM or its Vendor to dispense Covered Prescription Services to Members.
- **Out-of-Network Pharmacy Claims.** A Claim for services provided by a pharmacy that is not a Network Pharmacy.
- **Pharmacy Benefit Plan.** That portion of the Benefits Booklet that describes Covered Prescription Services that is administered by PBM. Pharmacy Benefit Plan coverage includes any deductible or co- insurance provided for under the Covered Prescription Services.

- **Prescription Drug.** FDA-approved drugs, biologics and drug compounds that are included in the U.S. Pharmacopoeia and that are required to be dispensed pursuant to a prescription or that are otherwise included in the Pharmacy Benefit Plan (e.g., certain over-the-counter drugs.
- **Prescription Drug Claim.** An electronic or paper claim for payment submitted as a result of Covered Prescription Drug Services provided to a Member and transmitted to PBM or Employer through PBM's online claims adjudication system or other means consistent with the terms of this Agreement.
- **Prescription Drug Rebates.** Any rebate and/or price protection payment associated with utilization that PBM receives and that is contingent upon and related directly to a Member's use of a Prescription Drug during the Agreement Period. Prescription Drug Rebates do not include any discount, price concession, Manufacturer Administrative Fees, or other direct or indirect remuneration PBM receives for the purchase of a Prescription Drug or for the provision of any products or services to manufacturer(s).
- **Pricing Source.** Medi-Span (or other nationally recognized third-party pricing source) selected by PBM in its sole discretion from time to time.
- **Retail Pharmacy.** A Network Pharmacy that provides Covered Prescription Services to Members at the point of sale or via delivery by an employee of the Network Pharmacy or contracted delivery courier. For purposes of clarification, delivery does not include mailing or shipping Covered Prescription Services to Members utilizing the United States Postal Service and/or other common shipping carrier, including FedEx and/or United Parcel Service.
- **Secondary Claims.** Claims where PBM is the secondary payer due to Coordination of Benefits.
- **Single Source Generics.** Those Generic Drugs that are provided by three or fewer pharmaceutical manufacturers as defined at the GPI14 level or such Generic Drugs that are in the market with supply limitations or competitive restrictions.
- **Specialty Drugs.** Specialty Drugs may be high-cost, injected, infused, oral, or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty Drugs may have special handling, storage, and shipping requirements, such as temperature control. Specialty Drugs are only those Prescription Drugs on PBM's Specialty Drug List.
- **Specialty Drug List.** The Specialty Drug list is a PBM developed and maintained list of Specialty Drugs that PBM may modify from time to time.
- **Specialty Pharmacy.** A Network Pharmacy that provides Specialty Drugs to Members.
- **Starter or Trial Claim.** A Prescription Drug for initial, limited-duration therapy intended to determine effectiveness or tolerance prior to continuation with a longer-term treatment plan.
- **Supplies.** Ancillary equipment, supplies, products and services provided or coordinated by a Network Pharmacy in connection with dispensing Covered Prescription Services to a Member under the Plan, including without limitation, nursing/clinical supplies, in-home infusion and related supplies, patient monitoring supplies, medication pumps, tubing, syringes, gauze pads, sharps containers, lancets, test strips, other supplies, and durable medical equipment.
- **Usual and Customary (U&C) Charge.** The retail cash price on the date the pharmaceutical is dispensed as submitted by the pharmacy on the Claim to PBM. The U&C Charge does not include non-funded prescription discount programs managed or promoted by a pharmacy.

B. Obligations of PBM.

PBM will provide the following pharmacy benefit management administrative and support services (the "PBM Services") listed below and in Exhibit B to the extent such services are applicable to the Pharmacy Benefit Plan:

1. **Network Pharmacy Services.**

   a. PBM shall offer Employer access to a network of pharmacies that have entered into contractual arrangements with PBM and/or its Vendors under which such pharmacies agree to provide pharmacy services to Members ("Network Pharmacies"). PBM shall determine, in its sole discretion, which pharmacies shall be Network Pharmacies, and the composition the network may change from time to time. PBM's network will provide Members access to Network Pharmacies to obtain Prescription Drugs.

PBM may consider Employer's request to add a specific pharmacy to its network and may do so, but is not required to, if the pharmacy meets PBM's network participation requirements and agrees to PBM's standard terms and conditions. Upon Employer's written request PBM may, but is not required to, remove a pharmacy from Employer's network.

b. PBM shall arrange for the dispensing of covered Prescription Drugs to Members through one or more networks of Network Pharmacies. If a Member obtains a covered Prescription Drug from a pharmacy that is not in the network, unless the Member has an out of network benefit, the Member may be responsible for the total cost of the covered Prescription Drug. Employer acknowledges that the availability of Prescription Drugs is subject to market conditions and that PBM cannot, and does not, assure the availability of any Prescription Drug.

c. PBM and/or its Vendors shall perform periodic audits of Network Pharmacies to ensure compliance with the terms and conditions of the Network Pharmacy agreements. PBM will pay Employer, or apply as a credit to invoices, one hundred percent (100%) of the amounts PBM recovers from these audits, minus a recovery fee as set forth in Exhibit A and, if applicable, Attachment 1 to Exhibit D. These audits are separate and distinct from daily Claims review audits, which are included in the list of services offered as part of the Pharmacy Administrative Services Fees as set forth in Exhibit B. Employer will be financially responsible for all expenses incurred in connection with audits of Network Pharmacies requested by Employer that are not required by applicable law.

d. Pursuant to the terms of the contract between PBM and Network Pharmacy, a Network Pharmacy shall not charge, collect a deposit from, or have any recourse against a Member for the covered Prescription Drugs other than the applicable cost sharing amount, including in the event of breach of the Agreement and/or this Pharmacy Services Schedule by Employer or insolvency of Employer. This provision shall survive the termination of this Pharmacy Services Schedule for any covered Prescription Drug provided to a Member prior to such termination.

e. Members may receive mail order Covered Prescription Services through PBM's Mail Order Pharmacy program. The Mail Order Pharmacy shall dispense Covered Prescription Drugs upon receipt from a Member of (i) a valid new or refill prescription order and (ii) applicable cost share. The covered Prescription Drug shall be mailed or shipped to the Member's address set forth in the eligibility file provided by Employer, or as appearing on the face of the prescription, so long as such address is within the United States. Additional fees for express mail, shipping or handling may be charged to Members. PBM may suspend such services to a Member if Member fails to pay any applicable cost share due.

f. Members may receive Specialty Pharmacy drug services through PBM's Specialty Pharmacy Program. PBM develops and modifies the Specialty Drug List from time to time.

g. PBM shall operate a toll-free call center to respond to inquiries from Network Pharmacies regarding Pharmacy Services provided by PBM pursuant to this Pharmacy Services Schedule, including but not limited to technical and claims processing issues and Member eligibility verification ("Pharmacy Help Desk"). The Pharmacy Help Desk shall be available 24 hours a day, 7 days a week.

h. Employer acknowledges that the availability of Prescription Drugs is subject to market conditions and that PBM cannot, and does not, assure the availability of any Prescription Drug. Certain pharmaceutical products may be subject to shortages, backorders, manufacturer discontinuations, or supply chain disruptions outside the reasonable control of the PBM or Network Pharmacies ("Drug Shortages"). In the event of a Drug Shortage, PBM will provide reasonable support to address the affected Drugs. For the duration of any Drug Shortage, neither Party will be subject to obligations related to the Drug Shortage, including but not limited to Performance Guarantees or the provision of alternative Prescription Drugs.

2. **Drug Formularies and Clinical Support.**

a. PBM will furnish and maintain a drug Formulary for use with the Pharmacy Benefit Plan, and PBM shall periodically review and update its Formulary. Employer shall adopt such Formulary as part of the design of the Pharmacy Benefit Plan. The drug Formulary will be made available to Members in a mutually acceptable format. PBM may, at its sole discretion, accept requests by Employer for custom drug placement on a Formulary; such Employer requests may result in pricing and guarantee adjustments, as determined by PBM.

b. PBM has placed certain Prescription Drugs on formularies that are developed through a two-step process called the Pharmacy & Therapeutics ("P&T") process. This process first uses an independent P&T committee of pharmacists and physicians that evaluate the clinical evidence of each product under review. During the second step of the process, a committee composed of members with various expertise combines the clinical review with an in-depth analysis of market dynamics, member impact, and financial value to make determinations about the formulary.

c. If a Formulary exception process is included in the Employer's Plan design, in the event a Member or Provider believes that a Prescription Drug or supply not included on a Formulary is medically necessary to treat the Member's individual condition, the Member or Provider may request a coverage exception by submitting the appropriate documentation to PBM.

3. **Claims Processing Services.**

a. PBM shall perform administrative services for Employer, including but not limited to, processing Claims with a Claims Incurred Date as indicated in Section 1 of Exhibit A for Covered Prescription Services in accordance with the Pharmacy Benefit Plan. PBM will pay, on Employer's behalf, only Claims that are timely and properly submitted by: (1) Network Pharmacies through PBM's point-of-sale service system; and (2) Members as requests for reimbursement for Covered Prescription Services. PBM may, at its sole discretion, process and pay denied Claims requested by Employer on an exception basis, subject to PBM system capability and a mutually agreed upon processing fee.

b. Upon Member request and without need for Employer authorization, PBM may implement certain administrative overrides to authorize the dispensing of Prescription Drugs that include, but are not limited to, requests for lost/stolen drugs and vacation supplies.

c. PBM shall disburse to Member or Network Pharmacies payments that PBM determines to be due according to the provisions of the Pharmacy Benefit Plan.

d. PBM shall provide notice to the Member and/or Provider, as required by law, when a Member-submitted Claim has been denied or a prior authorization request has been denied. Such notice shall satisfy applicable law governing the notice of a denied Claim.

e. As referenced in Exhibit A and, if applicable, Attachment 1 to Exhibit D, notwithstanding anything to the contrary in the Agreement, PBM will provide pharmacy Coordination of Benefits (COB) services as described in this Section e. Employer shall be responsible for providing other party insurance liability information for Members on its eligibility file. If the eligibility file is provided by Employer and PBM determines that coverage under this Agreement is deemed secondary, the Member Claim will reject at point of sale and instruct the Member to submit the Claim to the third-party payer that is deemed primary. PBM shall coordinate benefits with the third-party payers as appropriate.

4. **Utilization and Clinical Management Programs and Edits.**

a. PBM will provide a concurrent drug utilization program that assists pharmacies in identifying potential drug interactions, incorrect drug dosage, and inappropriate drug use and misuse. The program utilizes real-time Member health and safety protocols designed to monitor and screen each claim against the Member's Prescription Drug profile and is designed to help promote appropriate Prescription Drug use and help prevent adverse Member reactions. PBM shall make available to prescribing Providers, subject to such prescribing Providers' system capabilities, electronic access to Member eligibility; Prescription Drug Formulary status; Member medication history; a listing of Formulary alternative Prescription Drugs; and applicable cost share.

b. In addition to the programs and edits outlined in Section 4(a), PBM may offer additional programs and edits to help ensure clinically appropriate use of Prescription Drugs, and effectively manage the cost of care that may include, but is not be limited to drug edits (i.e. prior authorization, step therapy, quantity limits, and dose optimization), enhanced fraud waste and abuse program, and medication review. Employer shall pay fees for the programs and edits selected by Employer as set forth in Exhibit A. Employer shall abide by all applicable policies and procedures of the programs selected and provide requested information prior to PBM initiating the service.

c. Employer shall adopt and abide by PBM's utilization and clinical management programs and edits as part of the design of the Pharmacy Benefit Plan. PBM, at its sole discretion, may accept requests by Employer for custom programs or edits related to utilization or clinical management; such Employer requests may result in pricing and guarantee adjustments, as determined by PBM.

5. **General Provisions.**

   a. PBM may require Employer to indemnify, to the extent permitted by law, and/or certify to PBM that regulatory requirements are met for certain customizations requested by Employer.

   b. PBM will make available a toll-free number staffed by personnel to address Member questions.

   c. PBM will provide Employer with PBM's standard management and utilization reporting package as described in Exhibit A attached to this Pharmacy Services Schedule. At the rate set forth in Exhibit A, PBM may prepare and provide Employer-requested custom and ad hoc reports within an agreed-upon time and format.

   d. PBM will provide Pharmacy Services in accordance with the Pharmacy Benefit Plan and the Plan Documents adopted by Employer.

   e. PBM will maintain all applicable licenses, permits, certifications, registrations, and/or other regulatory approvals necessary for the performance of PBM's obligations pursuant to this Pharmacy Services Schedule.

   f. PBM may maintain at least one of the following accreditations during the term of the Agreement and this Pharmacy Services Schedule: (a) National Committee for Quality Assurance ("NCQA") certification; (b) URAC Pharmacy Benefit Management accreditation; and/or (c) such other certifications and accreditations selected by PBM. Employer shall not require PBM to take any action, or refrain from taking any action, that would reasonably be expected to jeopardize, impair, or otherwise put at risk such accreditations.

   g. PBM shall not be responsible for any adverse consequences from Employer's request to change from one pharmacy benefit administrator to another pharmacy benefit administrator.

   h. PBM agrees to be bound by its obligations under HIPAA as a Business Associate under the same terms as entered into by Rocky Mountain Hospital and Medical Service, Inc. dba Anthem Blue Cross and Blue Shield under its Business Associate Agreement with Employer.

C. **Obligations of Employer**. To the extent not already provided under Article 3 of this Agreement, Employer shall:

1. Provide Rocky Mountain Hospital and Medical Service, Inc. dba Anthem Blue Cross and Blue Shield with timely, accurate and complete information necessary to provide the Pharmacy Services. Rocky Mountain Hospital and Medical Service, Inc. dba Anthem Blue Cross and Blue Shield and PBM shall be under no obligation to verify the accuracy or completeness of information provided to it by Employer.

2. Provide accurate, timely, complete, and ongoing Member eligibility information to Rocky Mountain Hospital and Medical Service, Inc. dba Anthem Blue Cross and Blue Shield using Rocky Mountain Hospital and Medical Service, Inc. dba Anthem Blue Cross and Blue Shield's prescribed format and methods. Such information shall include, but is not limited to, the number and names of Members eligible for, and covered under, the Pharmacy Benefit Plan and any other information determined by Rocky Mountain Hospital and Medical Service, Inc. dba Anthem Blue Cross and Blue Shield to be necessary to provide Pharmacy Services. The Rocky Mountain Hospital and Medical Service, Inc. dba Anthem Blue Cross and Blue Shield and PBM will be entitled to rely on the accuracy and completeness of the Member eligibility data from Employer. Employer shall be solely responsible for any errors in Member eligibility data that Employer provides to Rocky Mountain Hospital and Medical Service, Inc. dba Anthem Blue Cross and Blue Shield and passed to PBM.

3. Review of Reports, Statements, and Invoices. Upon receipt from PBM of reports, statements and invoices by Employer or its designee(s), Employer shall be responsible for promptly reviewing and confirming that the reports, statements, and invoices are accurate and complete and promptly notifying PBM, in writing, of any errors or objections to such reports, statements, and/or invoices. Unless Employer notifies PBM in writing of any errors or objections within 90 days from receipt of such report, statement, and/or invoice, all the information contained therein will be deemed accurate, complete, and acceptable to Employer.

D. Drug Rebate Management.

1. During any Agreement Period, Employer shall not contract, directly or indirectly through a third-party, with a manufacturer or any other third-party for Prescription Drug, discounts, or other financial incentives on claims that are eligible for Prescription Drug Rebates under this Agreement. In the event that PBM determines such violation of this paragraph, Employer shall be deemed ineligible to earn Prescription Drug Rebates, the Drug Rebate Program will be suspended, and Employer shall be required to reimburse PBM for any Prescription Drug Rebates that were previously earned. If Employer fails to reimburse PBM for such Prescription Drug Rebates within 10 business days of PBM's request, PBM shall have the right to recover said amounts by offsetting such amounts against any amounts PBM owes Employer under this Agreement or any other agreement between Employer and PBM. Additionally, PBM may revise the guarantees and/or any pricing terms of the Agreement.
2. PBM will use reasonable efforts to negotiate and collect Prescription Drug Rebates from manufacturers. PBM shall not be required to institute litigation to negotiate and collect Prescription Drug Rebates from manufacturers. If PBM or its designee does elect to bring suit to recover Prescription Drug Rebates from manufacturers, PBM shall be entitled to deduct Employer's proportionate share of the reasonable attorney's fees and other expenses incurred in such litigation prior to payment of the applicable share of Prescription Drug Rebates to Employer. Neither Party shall be responsible to the other Party, its affiliates, directors, employees, agents, successors, or permitted assigns for any claim arising from: (i) any failure by a manufacturer to pay any Prescription Drug Rebates; (ii) any breach of an agreement relating to the transactions contemplated by or otherwise relating to this Agreement by any manufacturer; or (iii) any negligence or misconduct of any manufacturer.
3. In the event that PBM, its Vendor, and/or manufacturer identifies through audit or other means that Employer has received an overpayment or an erroneous Prescription Drug Rebate payment, Employer shall immediately refund such amounts. If Employer fails to do so, PBM shall have the right to recover said amounts by offsetting such amounts against any amounts PBM owes Employer under this Agreement or any other agreement between Employer and PBM.
4. Prescription Drug Rebates paid pursuant to the Agreement and Exhibit A of this Pharmacy Services Schedule are intended to be treated as "discounts" pursuant to the Federal Anti-Kickback Statute set forth at 42 C.F.R. § 1320a-7b, its implementing regulations and any appliable state equivalent.
5. Employer acknowledges and agrees that (i.) PBM is not required to pay Prescription Drug Rebates, allowances, credits, or guarantees until Employer has fully executed this Pharmacy Benefit Services Schedule and (ii.) the amount of any Prescription Drug Rebates paid to Employer will be net of any such amounts that PBM uses to enhance the overall value of Pharmacy Services and/or reduce fees or expenses.

E. Pharmacy Base Administrative Services Fees and Expenses

1. Employer agrees to pay PBM fees for the Pharmacy Services as set forth on Exhibit A.
2. PBM's fees for the Pharmacy Services may be revised in the event of substantial changes that would increase or decrease the obligations or costs of providing the Pharmacy Services, including but not limited to changes in the Pharmacy Benefit Plan, legislative changes, or postal rate changes. In addition to other rights set forth in Article 18(c) of the Agreement, PBM shall have the right to change the Pharmacy Base Administrative Services Fees or other fees provided in Exhibit A if: (a) PBM is no longer the sole provider of the Covered Prescription Services contemplated in this Pharmacy Services Schedule; (b) Employer implements an on-site pharmacy; or (c) a change in applicable law occurs resulting in an increase in the cost or amount of Covered Prescription Services under this Agreement. PBM shall provide notice to Employer of the change in the Pharmacy Base Administrative Services Fees at least 30 days prior to the implementation date of such change. Any change in the Pharmacy Base Administrative Services Fees will be effective as of the date the change occurs, even if that date is retroactive. If such change is unacceptable to Employer, either Party shall have the right to terminate this Pharmacy Services Schedule by giving written notice of termination to the other Party before the effective date of the change. If Employer accepts the proposed Pharmacy Base Administrative Services Fees, PBM shall provide a revised Exhibit A, and, if applicable, Schedule A, that will then become part of this Agreement without the necessity of securing Employer's signature on the Exhibit and, if applicable, Schedule A.
3. Employer shall be responsible for out-of-pocket production costs, travel expenses, and banking expenses incurred by PBM in carrying out implementation activities at the request of Employer.

4. PBM shall not provide or be responsible for the expenses or costs of services furnished by attorneys, actuaries, certified public accountants, investment counselors, or investment analysts, or for similar services performed for Employer. PBM shall not be authorized to engage such services or incur any expense or cost without the written consent of Employer. In the event that such services are engaged by PBM at the written request of Employer, Employer shall be responsible for all costs and expense thereof, that shall be separately billed by the provider of the services or by PBM as incurred.

5. Employer agrees to pay PBM fees for Claims Runout Services described in Section 5 of Exhibit A of this Pharmacy Services Schedule.

F. <u>Audits.</u>

1. To the extent any conflict exists between this Section F of this Pharmacy Services Schedule and the Claims audit provisions in Article 12 of the Agreement, the terms and conditions of this Pharmacy Services Schedule shall govern with respect to the provision of Pharmacy Services.

2. Employer may audit PBM directly or through a mutually acceptable third-party auditor. Employer must provide at least 60 days prior written notice to PBM of its intent to conduct an audit of PBM's compliance and performance under this Pharmacy Services Schedule. The scope of an audit including time, place, type and duration of all audits must be reasonable, mutually agreed to in writing by the Parties prior to the commencement of the audit, and in accordance with PBM's audit procedures and guidelines.

   a. Benefit Claims Audit.

      Employer may conduct an audit once each Contract Year and such audit may only relate to the last two preceding Contract Years from the current Contract Year (the “Audit Period”). Neither Employer nor anyone acting on Employer’s behalf shall have a right to audit for the period prior to the Audit Period. A benefit claims audit includes 100% of the Claims during the Audit Period. Of the 100% of Claims audited, PBM will review a representative sample of no more than 250 randomly selected Prescription Drug Claims selected by the auditor.

   b. Financial Audits.

      Employer may audit pricing performance guarantees, rebate performance guarantees, rebate credit and pharmaceutical company contracts once each Contract Year and such audit may only relate to the last preceding Contract Year from the current Contract Year (the “Financial Audit Period”). Neither Employer nor anyone acting on Employer’s behalf shall have a right to audit for the period prior to the Financial Audit Period.

      Employer, through an independent third-party auditor, shall be entitled to perform a review of up to 10 pharmaceutical company contracts directly related to Employer’s Prescription Drug Rebates. PBM will share such contracts with Employer’s third-party auditor during an onsite audit. Any such audit shall be contingent upon Employer’s third-party auditor signing a confidentiality agreement acceptable to PBM.

3. Benefit Claims and Financial Audit Procedures.

   a. Any audit shall be contingent upon Employer’s third-party auditor executing PBM’s confidentiality agreement prior to conducting an audit.

   b. No Audit Period may be audited twice unless required by a governmental body. An audit performed pursuant to this Pharmacy Services Schedule shall be the final audit for the Audit Period and for any prior Audit Period unless otherwise agreed to in writing by the Parties.

   c. Onsite audits and access to Claims processing systems will not be permitted except as otherwise provided herein.

   d. Employer shall provide to PBM copies of all final audit reports within 30 days of PBM's responses to in-scope audit requests or at the same time as they are made available by the third-party auditor to Employer. PBM shall have a minimum of 60 days to review and respond to each audit finding. Employer or its respective auditor shall have 30 days to respond to PBM's response to each audit finding. If Employer or its respective auditor fails to provide a final audit report within the timeframe set forth above or fails to respond within 30 days of PBM’s response, the audit will be considered closed.

   e. Any errors identified and/or amounts identified as owed to Employer as the result of the audit shall be subject to PBM’s review and approval prior to initiating any recoveries pursuant to this Pharmacy Services Schedule.

f. PBM reserves the right to terminate any audit being performed by or for Employer if PBM determines that the confidentiality of PBM's information is not properly being maintained or if PBM determines that Employer or the auditor is not following PBM's audit policy.

g. Employer acknowledges and agrees that Employer is not entitled to audit: (i) documents that are identified as proprietary or trade secret; and (ii) documents that PBM is barred from disclosing by law. All information and records reviewed pursuant to this Section F of this Pharmacy Services Schedule shall be considered Confidential Information for purposes of this Pharmacy Services Schedule.

4. Third-party auditors must be independent and objective with no breach of PBM's Confidential Information. Any Employer requests for a third-party auditor to audit will constitute Employer's direction and authorization to PBM to disclose Employer-specific information, including Member information and PHI, to Employer's auditor. PBM will provide Employer's auditor with access to all applicable Employer-specific information reasonably necessary to determine the accuracy of Claims payments and verify PBM's performance under this Pharmacy Services Schedule, subject to PBM's third-party confidentiality obligations; provided, however, any other documentation requested during the course of an audit not in the audit scope or necessary for the audit, will be provided at PBM's discretion.

5. Employer shall not be permitted to audit any contract between PBM and Network Pharmacies or Vendors.

G. Termination. In addition to the provisions in Article 19 of this Agreement,

1. Either Party may terminate this Pharmacy Services Schedule without cause by giving 90 days' notice prior to the date of the termination, subject to any applicable early termination penalty as set forth in Exhibit A.

2. This Pharmacy Services Schedule shall terminate on the date the Agreement is terminated unless otherwise agreed to by the Parties. If the Parties agree to continue this Pharmacy Services Schedule after termination, applicable provisions of the Agreement shall remain in effect until a new agreement is reached by the Parties.

3. This Pharmacy Services Schedule shall terminate on the effective date of any governmental body's action that prohibits all activities contemplated under this Pharmacy Services Schedule.

4. Following termination of only this Pharmacy Services Schedule, the remainder of the Agreement shall continue in full force and effect during the Agreement Period. Termination of this Pharmacy Services Schedule will not terminate the rights or obligations of either Party arising out of the period during which the Agreement was in effect.

5. In the event of termination of this Pharmacy Services Schedule, PBM shall not be responsible for notifying Members of such termination or of the procedure to be followed to retain or obtain Plan coverage.

6. Upon notice of termination of this Pharmacy Services Schedule for any reason other than for non-payment of amounts due under this Schedule, the Parties will mutually develop a transition plan that includes but is not limited to: (1) a schedule of transition activities and timelines for completion; (2) a detailed description of the respective roles of PBM and Employer; and (3) such other information and planning as necessary to ensure that the transition takes place according to an agreed upon schedule and with minimum disruption to Members. The transition plan shall be subject to written approval by both Parties.

7. Unless mutually agreed to in writing by the Parties, upon termination of this Pharmacy Services Schedule, Employer shall cease adoption and use of PBM's Formulary as part of its Plan and agrees that it shall not copy, distribute, or sell PBM's Formulary.

H. **Indemnification.**

PBM and Employer shall hold harmless, indemnify and defend, to the extent permitted by law, the other Party, and its directors, officers, shareholders, employees, agents and affiliates, from and against any third-party losses, claims, damages, liabilities, costs and expenses (including without limitation, reasonable attorneys' fees and costs) imposed upon or incurred by the indemnified Party arising out of or as a result of the negligence or willful misconduct of the indemnifying Party or its Vendors or subcontractors in the performance of the obligations under this Pharmacy Services Schedule. The obligation to provide indemnification under this Pharmacy Services Schedule shall be contingent upon the Party seeking indemnification: (1) providing the indemnifying Party with prompt written notice of any claim for which indemnification is sought; (2) allowing the indemnifying Party to control the defense and settlement of such claim; provided, however, that the indemnifying Party agrees not to enter into any settlement or compromise of any claim or action in a manner that admits fault or imposes any restrictions or obligations on an indemnified Party without that indemnified Party's prior written consent, which consent will not be unreasonably withheld; and (3) cooperating fully with the indemnifying Party in connection with such defense and settlement. Failure to provide prompt notice as set forth herein shall only constitute a violation of this Section H of this Pharmacy Services Schedule to the extent such failure materially prejudices the indemnifying Party with respect to its obligations to defend and indemnify pursuant to this Section H of this Pharmacy Services Schedule. To the extent any conflict exists between this Section H of this Pharmacy Services Schedule and the indemnification provisions in Article 16 and 17 of the Agreement, the terms and conditions of this Pharmacy Services Schedule shall govern with respect to the provision of Pharmacy Services.

I. Confidentiality.

Each Party retains all right, title, and interest in and to its Work Product, materials, and intellectual property, whether created, developed, conceived, authored, or otherwise acquired prior to or during the term of this Agreement, including but not limited to patents, trademarks, copyrights, trade secrets, software and technology, databases and data rights, and any other intellectual, industrial, or proprietary rights of a similar nature that may exist now or in the future, whether arising by statute, common law, or contract. Neither Party conveys ownership rights nor acquires ownership rights in the other Party's work product, materials, or intellectual property by entering into this Agreement or performing its obligations hereunder. Nothing in the Agreement shall impair or limit a Party's right to use and disclose its work product, materials, or intellectual property for its own lawful business purposes. "Work Product" means any ideas, concepts, discoveries, information, improvements, designs, data, documentation, software and other materials that PBM, whether alone or together with others, conceives, creates, develops or prepares in connection with the Pharmacy Services, together with all associated intellectual property rights.

J. Inconsistencies.

As related to Pharmacy Services, in the event of a conflict, inconsistency, or ambiguity between the provisions of this Pharmacy Services Schedule, its Exhibits, and the Agreement, such conflict, inconsistency, or ambiguity shall be resolved by giving precedence in the following order: i) state or federal law, rule, regulation, or ordinance; ii) the Exhibits to this Pharmacy Services Schedule; iii) this Pharmacy Services Schedule; and iv) the Agreement. Except as otherwise set forth herein, all other terms and conditions of the Agreement remain in full force and effect to the extent applicable, and the terms and conditions in the Agreement apply in full force and effect between PBM and Employer.

IN WITNESS WHEREOF, the Parties have executed this Schedule to be effective as of the Effective Date.

City of Littleton	
By:	
	Kyle Schlachter, Mayor
Date:	

Rocky Mountain Hospital and Medical Service, Inc. dba Anthem Blue Cross and Blue Shield	
By:	
	Matt Pickett, Plan President
Date:	

APPROVED AS TO FORM:

By:_____

Reid Betzing, City Attorney

Date:_____

CarelonRx, Inc.	
By:	
Title:	
Date:	

EXHIBIT A – FINANCIALS
OF THE PHARMACY BENEFITS ADMINISTRATIVE SERVICES SCHEDULE
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
City of Littleton

This Exhibit A shall govern from 1/1/2026 through 12/31/2028 and is made part of this Pharmacy Benefits Administrative Services Schedule. This Exhibit is intended to supplement the Agreement between the Parties as it relates to Pharmacy Services only.

Section 1. Effective Date and Renewal Notice

Paid Claims shall be processed pursuant to the terms of this Pharmacy Services Schedule when incurred during the Agreement Period from 1/1/2026 through 12/31/2028.

PBM may provide any offer to renew this Pharmacy Services Schedule not less than 90 days prior to the end of an Agreement Period.

Section 2. Broker or Consultant Base Compensation

Not Applicable

Section 3. Pharmacy Administrative Services Fees

Change to Administrative Services Fees. The Administrative Services Fees in Section 3 of Schedule A of the Agreement and the Pharmacy Administrative Services Fees in Section 3 of Exhibit A may be changed during the Agreement Period based upon an event in Article 18(c) of the Agreement or Section E (2) of this Pharmacy Services Schedule.

A. Pharmacy Base Administrative Services Fee

The Pharmacy Administrative Services Fees shall also include a fee that will be charged monthly for services related to pharmacy benefits management including, but not limited to, pharmacy mail services, clinical services, and customer services. Such fee shall be:

$0.00.

B. Drug Rebate Allocation

PBM has negotiated programs with pharmaceutical manufacturers for drug rebates on PBM's behalf and not on behalf of Employer, and therefore PBM retains all rights, title and interest to any and all rebates it receives from manufacturers and/or its Vendor.

Minimum Pharmacy Rebate Offset and Guarantee: PBM shall transfer to Rocky Mountain Hospital and Medical Service, Inc. dba Anthem Blue Cross and Blue Shield an amount that will be used by Rocky Mountain Hospital and Medical Service, Inc. dba Anthem Blue Cross and Blue Shield to reduce the Base Administrative Services Fee set forth in Section 3(A) of Schedule A. The amount of such offset, also referred to as the Pharmacy Rebate Offset is set forth in Section 3(A) of Schedule A. PBM shall reconcile each quarter the Pharmacy Rebate Offset that Employer received against the amount representing 100% of the actual Prescription Drug Rebates PBM received attributable to Employer's Plan. If the actual Prescription Drug Rebate amount the PBM receives is greater than the Pharmacy Rebate Offset the Employer received from PBM, then PBM shall return the difference between the actual Prescription Drug Rebate amount and the Pharmacy Rebate Offset to the Employer.

PBM shall have the right to collect from Employer any Prescription Drug Rebate amount that PBM is required to pay a pharmaceutical manufacturer as a result of a pharmaceutical manufacturer audit or for any other reason. Provided, however, if the total Prescription Drug Rebates Performance Guarantee as defined in Exhibit C, or the Pharmacy Rebate Offset exceeds the amount described herein, the PBM will pay the Employer the difference.

Medical Drug Rebates: PBM shall retain 100% of the Medical Drug Rebates.

C. Other Fees or Credits

Fee for Pharmacy Prior Authorization. $55.00 per authorization.

Fee for Step Therapy. PBM shall charge a fee of $0.30 per pharmacy Claim.

Fee for Quantity Limits. PBM shall charge a fee of $0.55 per pharmacy Claim for applying frequency and quantity limits to certain Prescription Drugs.

Fee for Pharmacy Physician Review. $800.00 per review.

Fee for Vaccine Administration. PBM shall charge a fee for the administration of vaccines at a Retail Pharmacy location of $2.50 per vaccine.

Fee for Custom Communications. PBM shall charge a fee of $2.00 per custom communication requested by the Employer.

Fee for Member-Submitted Claims. PBM shall charge a fee of $2.50 per Claim for each Member-submitted Claim.

Fee for Clinical Care Gap Outreach Program (Enhanced)(also referred to as Rx Care Nexus Program). PBM shall charge a fee of $0.75 per pharmacy claim for additional clinical scope and chronic conditions managed, increased actionable interventions, and expansion of clinical programs such as: behavioral health management, adherence, outreach, new start education, Formulary alternatives, primary non-adherence, and clinical safety and efficacy.

Fee for Specialty Cost Optimization. PBM shall retain the difference between the amount charged to Employer for Specialty Drugs subject to the Specialty Cost Optimization Program and the amount charged to PBM as reasonable compensation for PBM's administration of the Specialty Cost Optimization Program.

Fee for Audit, Overpayment, and Prevention Activities. Employer will be charged 25.00% of amounts recovered through (i) audits of Network Pharmacies and Vendors, (ii) reviews of Claims and membership data that identify overpayments, and (iii) activities including, but not limited to, compliance with billing and contract requirements, claims accuracy, Coordination of Benefits, Secondary Claims, and eligibility. These services are separate from routine Claims processing and financial accuracy audits.

Fee for Pharmacy Coordination of Benefits. Included in the Pharmacy Administrative Services Fee.

Fee for Cost Relief Program. The charge to Employer for PBM's management of the Cost Relief Program is 25.00% of the Shared Savings. Shared Savings means the amount PBM collects from pharmaceutical manufacturers through the Cost Relief Program multiplied by a 5.00% discount factor.

Pass-Through Pricing Administrative Fee. PBM shall charge a fee of $1.50 per Prescription Drug Claim in those applicable states that do not permit margin pricing.

State Regulatory Impact Fee. PBM shall charge a fee of $0.30 per Prescription Drug Claim from a state with regulatory requirements impacting the provision of Pharmacy Services.

Third-Party Retail Appeal Fee. $130.00 per appeal submitted by a Retail Pharmacy under a state-mandated appeal process for retail claims.

Fee for Member Communications. PBM shall charge a fee of $1.30 per Member communication/letter for the following programs:

- Non-FDA Approved Drug Block
- Re-Labeler Program
- Safety Communications /Drug Recalls and Withdrawals
- New Implementation Formulary Disruption Letters
- Commercial Formulary Member Notifications
- Employer-directed communications

Fee for Employer Reporting – Base Package. PBM's Base Package is included at no cost and includes access to CII Evolve (unlimited). CII Evolve is the client reporting tool providing spend, trend, and utilization, product savings and self-service product modeling capabilities.

All custom reporting requests will be charged at $150.00 per hour of time needed to generate customized ad hoc reports.

Pharmacy Services Schedule Early Termination Fee. If Employer terminates this Pharmacy Services Schedule before the end of the Agreement Period for any reason other than PBM's failure to comply with a material duty or obligation related to the administration of pharmacy benefits under this Pharmacy Services Schedule, Employer shall pay PBM the early termination fee described below.

The Early Termination Fee shall be calculated by multiplying $3.00 PSPM by (i) the average monthly Subscriber count for the 6 months immediately prior to termination; multiplied by (ii) the number of months remaining in the Agreement Period. In the event Employer terminates this Pharmacy Services Schedule before the end of the Agreement Period, the applicable early termination fee will be billed to Employer with the amount due within 30 days of the termination effective date.

Invoices for Prescription Drug Claims When PBM invoices Employer for Prescription Drug Claims, the amount billed will reflect pricing that may be greater than, or less than, the amount that is paid to pharmacies for those Claims.

Ongoing Pharmacy Management Allowance Credit. Employer shall receive an ongoing Pharmacy Management Allowance Credit ("Ongoing PMA Credit") in the amount of $12.00 for year 1 of the Agreement Period, $12.00 for year 2 of the Agreement Period, $12.00 for year 3 of the Agreement Period, per member per each year of the Agreement Period for those members enrolled in the Plan as of the first day of each year of the Agreement Period. The Ongoing PMA Credit shall be apportioned across all lines of business based on either drug spend or Member lives. This Ongoing PMA Credit shall be used by Employer to offset the cost of legitimate, necessary, and commercially reasonable services that are directly related to administering and managing the pharmacy benefit and/or enhancing the value of Employer's pharmacy program. Subject to PBM approval, the Ongoing PMA Credit may be used for items including:

- Custom communication services provided by either PBM or an outside vendor
- Implementation expenses
- Clinical programs offered by Anthem and/or PBM
- Consulting fees (if directly related to Employer's pharmacy benefit)
- IT programming
- Data and other fees charged by other vendors related exclusively to Pharmacy Services
- Wellness programs offered by Anthem and/or PBM
- Additional reporting or data feeds equal to the actual billed charges
- Any other pharmacy related expense not referenced above that PBM approves in advance.

Employer shall submit all requests for reimbursement under the Ongoing PMA Credit noted above to PBM with documentation of Employer expenses and costs no later than 30 days after the end of each year of the Agreement Period. PBM shall reimburse Employer within 30 days of receipt of Employer's request and supporting documentation. Such reimbursement will be in the form of a credit on Employer's invoice. Any unused portion of the Ongoing PMA Credit for the current Contract Year will not carry forward to the next Contract Year. Any funds remaining 30 days after the end of each year of the Agreement Period will be retained by PBM. PBM will not reimburse Employer's vendors directly.

In the event that Employer terminates the pharmacy portion of this Agreement prior to the end of the Agreement Period for any reason other than PBM's failure to comply with a material duty or obligation related to the administration of the pharmacy portion of Plan benefits under this Agreement, Employer shall forfeit any unused credits and shall reimburse PBM for any utilized credits within 30 days of the termination of this Pharmacy Services Schedule.

It is the intention of the Parties that, for the purposes of the Federal Anti-Kickback Statute, this Ongoing PMA Credit shall constitute and shall be treated as a discount against the price of drugs within the meaning of 42 U.S.C. 1320a-7b(b)(3)(A). To the extent required by laws or contractual commitment, Employer agrees to fully and accurately disclose and report any such discount, rebate, credit or allowance to Medicare, Medicaid or other government health care program as a discount against the price of the Prescription Drugs provided under this Pharmacy Services Schedule.

Unidentified Recoveries. PBM shall retain any funds received through recovery processes that are paid to PBM and, following good faith and reasonable efforts, cannot be tied to a specific Employer or Member.

Section 4. Pharmacy Administrative Services Fees and Paid Claims Billing Cycle and Payment Method

Billing cycles and payment methods are contained in Schedule A of the Agreement.

Section 5. Claims Runout Services

A. **Claims Runout Period**

Claims Runout Period shall be for the 12 months following the date of termination of this Pharmacy Services Schedule.

B. **Claims Runout Administrative Services Fee**

Pharmacy:

The fee for Claims Runout Services will be waived. Fees in Section 3(C) of this Exhibit A that (i) are associated with Claims processed or reviewed during the Claims Runout Period including without limitation subrogation fees, Claims prepayment analysis fees, recovery fees, network access fees; or (ii) apply to this Pharmacy Services Schedule Period but were not billed during this Pharmacy Services Schedule Period, will be billed and payable during the Claims Runout Period. Payment is due to PBM by the Invoice Due Date.

Section 6. Other Amendments. The Pharmacy Benefits Administrative Services Schedule is otherwise amended as follows: N/A.

EXHIBIT B – PHARMACY SERVICES
OF THE PHARMACY BENEFITS ADMINISTRATIVE SERVICES SCHEDULE
TO THE
ADMINISTRATIVE SERVICES AGREEMENT
WITH
City of Littleton

This Exhibit B shall govern the Agreement Period from 1/1/2026 through 12/31/2028 and is made part of this Pharmacy Benefits Administrative Services Schedule. This Exhibit is intended to supplement the Agreement between the Parties as it relates to Pharmacy Services only. In the event of an inconsistency between the applicable provisions of this Pharmacy Services Schedule and the Agreement, the terms of this Pharmacy Services Schedule shall govern, but only as they relate to Pharmacy Services. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

The following is a list of standard services that PBM will provide under this Pharmacy Services Schedule for the Pharmacy Administrative Services Fees set forth on Section 3 of Exhibit A. These services will be furnished to Employer in a manner consistent with PBM's standard policies and procedures for self-funded plans. PBM may also offer services to Employer that have an additional fee. If Employer has purchased such services, those services and any additional fees are also set forth on Exhibit A.

Prescription Benefit Services

- Mail Order Pharmacy
- Specialty Pharmacy Services
    - Prescription eServices
    - Pharmacy locator
    - Online Formulary
- Point of sale Claims processing (not including pharmacy COB services)
- Mail order Claims processing
- Mail order call center with toll free number
- Mail order regular mailing or shipping and handling
- Standard management reports
- Concurrent Drug Utilization Review (DUR) programs
- Retrospective DURs
- Pharmacy help desk with toll free number
- Daily Claims review audits of Network Pharmacies
- Assistance in determining "creditable prescription drug coverage" under Medicare Part D
- Integration of medical and pharmacy Claims data for proactive prior authorizations (i.e., a Member's diagnosis from medical Claims is incorporated into the pharmacy Claim system to seamlessly approve prior authorizations where diagnoses are required)

EXHIBIT C - PERFORMANCE GUARANTEES
OF THE PHARMACY BENEFITS ADMINISTRATIVE SERVICES SCHEDULE
TO THE
ADMINISTRATIVE SERVICES AGREEMENT
WITH
City of Littleton

This Exhibit C provides certain guarantees pertaining to PBM's performance under the Agreement between the Parties ("Performance Guarantees") and shall be effective for each Contract Year from 1/1/2026 through 12/31/2028 (the "Performance Period"). Descriptions of the terms of each Performance Guarantee applicable to the Parties are set forth in the Attachments (the "Attachments") to this Exhibit C and made a part of this Exhibit C. This Exhibit shall supplement and amend the Pharmacy Benefits Administrative Services Schedule between the Parties.

Section 1. General Conditions

A. The Performance Guarantees described in the Attachments to this Exhibit C shall be in effect only for the Performance Period indicated above, unless specifically indicated otherwise in the Attachments. Each Performance Guarantee shall specify a/an:

1. Allocation. The term Allocation is the percent of total Amount at Risk to each Performance Guarantee.
2. Amount at Risk. The term Amount at Risk means the amount PBM may pay if it fails to meet the target(s) specified under the Performance Guarantee.
3. Measurement Period. The term Measurement Period is the period of time under that PBM's performance is measured, that may be the same as or differ from the period of time equal to the Performance Period.
4. Performance Category. The term Performance Category describes the general type of Performance Guarantee.
5. Reporting Period. The term Reporting Period refers to how often PBM will report on its performance under a Performance Guarantee.
6. Service Feature. The term Service Feature is a service standard stipulated and defined to be guaranteed.

B. PBM shall conduct an analysis of the data necessary to calculate any one of the Performance Guarantees within the timeframes provided in the Attachments to this Exhibit C. In addition, any calculation of Performance Guarantees, reports provided, or analysis performed by PBM shall be based on PBM's then current measurement and calculation methodology, that shall be available to Employer upon request.

C. The calculation and reconciliation of Performance Guarantees related to Specialty Drugs will include only the Specialty Drugs identified on PBM's Specialty Drug List.

D. If the Agreement is not executed, PBM shall have no obligation to make payment under these Performance Guarantees.

E. Unless otherwise specified in the Attachments to this Exhibit C, the measurement of the Performance Guarantee shall be based on data that is maintained and stored by PBM or its Vendors.

F. If Employer terminates the Agreement or this Pharmacy Services Schedule between the Parties prior to the end of the Performance Period, or if the Agreement or this Pharmacy Services Schedule is terminated for non-payment, then Employer shall forfeit any right to collect any further payments under any PBM programs or Performance Guarantees.

G. Performance Guarantees apply only as long as there are 7,024 Annualized Adjusted Prescription Drug Claims.

H. Reservation of Rights.

1. Employer Plan Changes. PBM reserves the right to modify the financial provisions of this Pharmacy Services Schedule if any of the following occur and to the extent of any adverse financial impact to the overall economic value of this Pharmacy Services Schedule: (a) a change in the scope of services to be performed under this Pharmacy Services Schedule upon which the financial provisions in this Pharmacy Services Schedule are based; (b) a change in Plan design; (c) material differences between Employer's actual utilization and the data and assumptions on which the financial provisions of this Pharmacy Services Schedule are based; or (d) any change in Formulary, including PBM's utilization management and programs, including but not limited to any addition or modification of products or programs that results in a reduction of Prescription Drug Rebates; (e) any instance of a Member's cost share exceeding the amount available under a direct-to-consumer cash price in the applicable market (collectively "Plan Changes").

   PBM agrees to inform Employer in writing of any modifications to the financial provisions resulting from an Employer Directed Change and discuss its rationale and calculations with Employer's consultant. PBM's modifications to the financial provisions will be effective as of the date of the Employer Plan Change, as determined by PBM.

   PBM shall have the right to revise Performance Guarantees in the event there is a greater than 25.00% change in membership demographics or Claims volume from the number provided to PBM during pricing negotiations on which the financial provisions of this Pharmacy Services Schedule are based.

2. Market Event Conditions. PBM reserves the right to modify or amend the financial provisions of this Pharmacy Services Schedule upon at least 30 days prior written notice, if possible, to Employer in the event of a government imposed change in federal, state or local laws or regulation or industry wide change that materially impacts the financial economics of this Pharmacy Services Schedule. In addition, any change to the methodology, availability, or publication of AWP shall constitute a Market Event Condition. For modifications or amendments made pursuant to this provision, PBM shall provide documentation demonstrating that the revised terms are based on the new industry standard. In the event Employer demonstrates the revised terms are not reflective of the new industry standard and the Parties are unable to reach agreement on revised terms, Employer may terminate this Pharmacy Services Schedule upon 90 days prior written notice.

3. Rebate Contingencies. Rebate Performance Guarantees and Prescription Drug Rebate are contingent upon PBM's entitlement and ability to collect Prescription Drug Rebates under the applicable agreement(s) between PBM and/or its Vendor and the pharmaceutical manufacturer, which are subject to change due to a variety of factors, including but not limited to Employer meeting manufacturer required criteria for Prescription Drug Rebates and the extent of Employer's participation in PBM's Formulary management, as well any actions or inactions by manufacturer that impact the availability or amount of Prescription Drug Rebate earned.

I. For the purposes of calculating compliance with the Performance Guarantees contained in the Attachments to this Exhibit C, if a delay in performance of, or inability to perform, a service underlying any of the Performance Guarantees is due to circumstances that are beyond the control of PBM, or its Vendors, including but not limited to any act of God, civil riot, floods, fire, pandemics, acts of terrorists, acts of war or power outage, such delayed or non-performed service will not count towards the measurement of the applicable Performance Guarantee.

J. As determined by PBM, Performance Guarantees may be measured using either aggregated data or Employer-specific Data. The term Employer-specific Data means the data associated with Employer's Plan that has not been aggregated with other Employer data. Performance Guarantees will specify if Employer-specific Data shall be used for purposes of measuring performance under the Performance Guarantee.

K. If any Performance Guarantees are tied to a particular program and its components, such Performance Guarantees are only valid if Employer participates in the program and its components for the entirety of the Measurement Period associated with the Performance Guarantee.

L. Employer acknowledges and agrees that each Performance Guarantee will be measured based on the Measurement Period as described in the Attachments to this Exhibit C and prorated to account for Employer specific Effective or renewal dates when measured using aggregated data. The Performance Guarantee will begin on the Employer Effective Date. However, if the Employer terminates the Pharmacy Benefits Schedule before the end of a Measurement Period, the Performance Guarantee measured will be based on the entire Measurement Period during which the termination occurred.

M. Any Pharmacy Implementation Performance Guarantee payment and/or any Pharmacy Operations Performance Guarantee payment owed to Employer represents Employer's sole and exclusive remedy for any failure by PBM to meet such Pharmacy Implementation Performance Guarantee and/or Pharmacy Operations Performance Guarantee; any such failure will not be deemed a material breach of this Pharmacy Service Schedule and PBM will have no additional liability.

Section 2. Payment

A. If PBM fails to meet any of the obligations specifically described in a Performance Guarantee described in the Attachments to this Exhibit C, PBM shall pay Employer the amount set forth in the Section describing the Performance Guarantee. Payment shall be in the form of a credit on Employer's invoice for Administrative Services Fees that will occur annually unless otherwise stated in the Performance Guarantee.

B. Notwithstanding the above, PBM has the right to offset any amounts owed to Employer under any of the Performance Guarantees contained in the Attachments to this Exhibit C against any amounts owed by Employer to PBM under: (1) any Performance Guarantees contained in the Attachments to this Exhibit C; or (2) the Agreement.

C. Notwithstanding the foregoing, PBM's obligation to make payment under the Performance Guarantees is conditioned upon Employer's timely performance of its obligations provided in the Agreement and the Pharmacy Schedule, in this Exhibit C and the Attachments, including providing PBM with the information or data required by PBM in the Attachments. PBM shall not be obligated to make payment under a Performance Guarantee if Employer or Employer's vendor's action or inaction adversely impacts PBM's ability to meet any of its obligations provided in the Attachments related to such Performance Guarantee, that expressly includes but is not limited to Employer or its vendor's failure to timely provide PBM with accurate and complete data or information in the form and format expressly required by PBM.

D. Where the Amount at Risk for a Performance Guarantee is on a percentage of a Per Subscriber Per Month (PSPM) fee basis, the Guarantee will be calculated by multiplying the PSPM amount by the membership count on the first day of the Measurement Period.

E. PBM shall reconcile the Pricing Performance Guarantees described in Attachment 1 to Exhibit C, to the extent applicable, on an annual basis, calculated in accordance with Section 4 of this Exhibit C. The reconciliation for each year of the Performance Period will be submitted to Employer within 90 days after the end of the Measurement Period and any resulting value shortfall shall by paid by PBM to Employer within 30 days following submission of the reconciliation report.

F. **Prescription Drug Rebate Pass-Through.** PBM shall pass through Prescription Drug Rebate amounts collected by PBM, as described in Attachment 1 to Exhibit C, to Employer on a quarterly basis in accordance with Section 3 of this Exhibit C. Such payments shall be made within 180 days after the end of the applicable quarter.

1. Additional Payments of Prescription Drug Rebate Collections. PBM will pass through any additional Prescription Drug Rebate amounts collected from prior quarters in subsequent quarterly disbursements.

2. Rebate Reconciliation. PBM shall reconcile the rebate Performance Guarantees, as described in Attachment 1 to Exhibit C, on an annual basis in accordance with Section 3 of this Exhibit C. The Prescription Drug Rebate reconciliation for each Measurement Period shall be submitted to Employer within 10 months following the end of such Measurement Period. Any resulting shortfall shall be paid by PBM to Employer within 30 days following submission of the reconciliation. Prescription Drug Rebates collected after the reconciliation, and attributable to the reconciled Measurement Period, shall be retained by PBM.

3. Cost Relief Program Adjustment. If Employer participates in PBM's Cost Relief Program, Employer agrees that any payment due under the Prescription Drug Rebate Performance Guarantee will be reduced by any amount of Prescription Drug Rebates retracted by a manufacturer(s) due to eligibility being modified, eliminated, or materially reduced under such program.

Section 3. Prescription Drug Rebate Performance Guarantees

A. Any payment due to Employer under a rebate Performance Guarantee will be offset by favorable results achieved in any other rebate Performance Guarantee.

B. This Performance Guarantee will be determined by comparing the total Prescription Drug Rebates Performance Guarantee to the Prescription Drug Rebates credited to the Employer pursuant to this Pharmacy Services Schedule and Section 3(B) of Exhibit A. If the total Prescription Drug Rebates Performance Guarantee exceeds the Prescription Drug Rebates credited to the Employer, PBM will credit Employer the difference.

C. For purposes of these Prescription Drug Rebate Performance Guarantees, the following Claims will not be included in the calculation:

- Medicare Part D Claims
- 340B Claims
- Vaccines
- Prescriptions filled through the Employer's on-site pharmacy
- Brand MAC
- Subrogated Claims
- Indian Health Pharmacy Claims
- Long Term Care Pharmacy Claims
- Home Infusion Pharmacy Drugs
- Military/Department of Veterans Affairs Pharmacy Claims
- Formulary Exception Claims
- Starter or Trial Claim
- Acute/Short-Term Claim
- Affordable Care Act (ACA) Claims
- COBRA Claims

D. The Parties acknowledge and agree that Prescription Drug Rebate Guarantees may be revised by PBM in the event of product offering decisions by drug manufacturers that result in: (a) a reduction of Prescription Drug Rebates, including the introduction of a lower cost alternative product which may replace an existing rebateable Brand Drug; (b) an unexpected launch of a Brand Drug and/or Generic Drug; (c) unforeseen delays in expected Brand Drug and/or Generic Drug launches; or (d) a Brand Drug converted to over-the-counter ("OTC") status, recalled or withdrawn from the market.

E. Prescription Drug Rebate Guarantees do not apply to Paid Claims processed through institutional, hospital or staff model/hospital pharmacies or through pharmacies that participate in the federal government pharmaceutical purchasing program.

F. COVID test kits, COVID anti-viral medication and COVID vaccines are excluded from the Prescription Drug Rebate Guarantees under this Pharmacy Services Schedule.

G. In the event that the drug manufacturer fails to pay or pays less than the invoiced amount, and such failure is unrelated to the performance of PBM, PBM shall account for the Prescription Drug Rebate performance guarantees Claim counts to reflect the lack of payment by the drug manufacturer.

H. In the event of market changes that impact drug price, including but not limited to a reduction in the WAC price for an innovator drug, or in the event that clinically comparable lower rebate Prescription Drugs impact the level of Prescription Drug Rebates expected, a Prescription Drug Rebate Credit toward the Prescription Drug Rebate Guarantee amount will be applied ("Prescription Drug Rebate Guarantee Credit"). This Prescription Drug Rebate Guarantee Credit will be calculated as the difference between the originator Brand Drug rebates and the new product rebates or the drug cost savings from a lower drug cost due to a pricing change from a pharmaceutical manufacturer, resulting in neutrality for Employer.

Section 4. Prescription Drug Pricing Performance Guarantees

A. To determine any payment due to Employer under these Prescription Drug Pricing Performance Guarantees, each Performance Guarantee is calculated based on the Prescription Drugs that were paid during the Measurement Period for:

- Retail Pharmacy
- Mail Order
- Retail 90
- Specialty Drugs

(each such subset of Paid Claims for Prescription Drugs is referred to as a "Pricing Guarantee Category").

Each guarantee within a Pricing Guarantee Category is then compared to the sum of appropriate portion of the Paid Claims for Prescription Drugs plus any Member cost shares associated with each Performance Guarantee within that Pricing Guarantee Category. Paid Claims for Prescription Drugs include Ingredient Costs plus Dispensing Fees. Therefore, Paid Claims for Prescription Drugs dispensed by a Retail Pharmacy are separated into Brand and Generic Ingredient Costs and Brand and Generic Dispensing Fees. These Ingredient Costs and Dispensing Fees are compared against each identified Performance Guarantee provided in this Pharmacy Services Schedule to determine if the Performance Guarantee is met.

B. Any payment due to Employer under any Performance Guarantee within a Pricing Guarantee Performance Category will be offset by favorable results achieved in any other guarantee regardless of the Pricing Guarantee Performance Category.

C. The following conditions apply to this Prescription Drug Pricing Performance Guarantee:

1. This Performance Guarantee applies to Claims submitted by Network Providers applicable to Employer's Plan.
2. Drugs identified at the time the prescription is filled as Single Source Generics, will be included in the Generic Discount and Generic Dispensing Fee Performance Guarantees.
3. Drugs identified at the time the prescription is filled as Brand MAC, will be included in the Generic Discount and Generic Dispensing Fee Performance Guarantees.
4. Drugs identified at the time the prescription is filled as Dispense As Written Claims with code 5 will be included in the Generic Discount and Generic Dispensing Fee Performance Guarantees.
5. COVID test kits, COVID anti-viral medication and COVID vaccines are excluded from the Prescription Drug Pricing Guarantees under this Pharmacy Services Schedule.
6. Claims for Covered Prescription Services delivered by a Retail Pharmacy to a Member will be included in the Retail Pharmacy Network Pricing Guarantees and not within the Mail Order Pharmacy Pricing Guarantees.
7. Prescription Drug Claims adjudicated from or in any state that mandates NADAC pricing will be excluded from Prescription Drug Pricing Performance Guarantees under this Pharmacy Services Schedule.
8. Limited Distribution Drugs will be included in the Specialty Drug Performance Guarantees.
9. This Pricing performance guarantee applies only if the Specialty Pharmacy designated by PBM is both (a.) the exclusive pharmacy that fills drugs on the Exclusive Network Drug List for Members, and (b.) the specialty mail penetration based on aggregate spend is greater than 80.00%. Specialty mail penetration is calculated by dividing total drug spend on Exclusive Network drug Claims filled at the Specialty Pharmacy designated by PBM by total drug spend on Exclusive Network drug Claims filled at all pharmacies.

D. The following Claims will be excluded from this Prescription Drug Pricing Performance Guarantee:

- Medicare Part D Claims
- 340B Claims
- Vaccines
- Prescriptions filled through the Employer's on-site pharmacy

- Compound Drugs
- Member-submitted Claims
- Coordination of Benefit (COB) Claims
- Secondary Claims
- Out-of-Network Claims
- Subrogated Claims
- Military/Department of Veterans Affairs Pharmacy Claims
- COBRA Claims

ATTACHMENT 1 TO EXHIBIT C
Performance Guarantees
TO ADMINISTRATIVE SERVICES AGREEMENT
WITH
City of Littleton

Pharmacy Performance Guarantees

This Attachment is made part of Exhibit C and will be effective for the Performance Period from 1/1/2026 through 12/31/2028. This Attachment is intended to supplement and amend the Agreement between the Parties. The Measurement Period for these Performance Guarantees will be annual, unless otherwise specified herein. These Performance Guarantees are guaranteed upon offer and acceptance of renewal of the medical portion of the Agreement.

Pharmacy Performance Guarantee	Measurement and Reporting Period
Prescription Drug Rebate Guarantees **NATIONAL DIRECT PLUS FORMULARY** **Minimum Drug Rebates:** (a) The Drug Rebates Employer receives from PBM will not be less than the following amounts ("Total Drug Rebates Guarantee"): **NON-SPECIALTY DRUGS** **BRAND NAME PRESCRIPTION DRUGS** (1) An amount equal to the sum of $350.00 (YR1) $375.00 (YR2) $400.00 (YR3) per Paid Claim for Non-Specialty Brand Name Prescription Drugs dispensed at Retail Pharmacies for a supply of less than 84 days; plus (2) An amount equal to the sum of $700.00 (YR1) $750.00 (YR2) $800.00 (YR3) per Paid Claim for Non-Specialty Brand Name Prescription Drugs dispensed at Retail Pharmacies for a supply of 84 days or greater. (3) An amount equal to the sum of $800.00 (YR1) $850.00 (YR2) $900.00 (YR3) per Paid Claim for Non-Specialty Brand Name Prescription Drugs dispensed at Mail Order Pharmacies. **SPECIALTY DRUGS** **BRAND NAME PRESCRIPTION DRUGS** (1) An amount equal to the sum of $3,500.00 (YR1) $3,700.00 (YR2) $3,900.00 (YR3) per Paid Claim for Specialty Brand Name Prescription Drugs dispensed at Pharmacies	**Measurement Period** Annual **Reporting Period** Annual

Pharmacy Performance Guarantee	Measurement and Reporting Period
Prescription Drug Pricing Guarantees **Prescription Drug Pricing:** (a) The Prescription Drug Pricing Guarantees for Ingredient Cost Discount and Dispensing Fees will be the amounts listed under the following Pricing Guarantee Categories: **BASE NATIONAL RETAIL PHARMACY NETWORK** The guarantees for Retail 30, Retail Pharmacies will be the following amounts (Retail Generic with all Days Supply will be reconciled in Retail 30 guarantees): 1. Brand Discount: AWP minus 19.50% (YR1) 19.50% (YR2) 19.50% (YR3) 2. Brand Dispensing Fee: $0.50 (YR1) $0.50 (YR2) $0.50 (YR3) 3. Generic Discount: AWP minus 86.00% (YR1) 86.15% (YR2) 86.30% (YR3) 4. Generic Dispensing Fee: $0.50 (YR1) $0.50 (YR2) $0.50 (YR3) **RETAIL 90 RETAIL PHARMACY NETWORK** The guarantees for Retail 90, Retail Pharmacies dispensing 84-90 day supplies will be the following amounts: 1. Brand Discount: AWP minus 22.00% (YR1) 22.00% (YR2) 22.00% (YR3) 2. Brand Dispensing Fee: $0.30 (YR1) $0.30 (YR2) $0.30 (YR3) **MAIL ORDER OPTIONS** **MAIL ORDER PHARMACY** The guarantees for mail order will be the following amounts: 1. Brand Discount: AWP minus 22.00% (YR1) 22.00% (YR2) 22.00% (YR3) 2. Brand Dispensing Fee: $0.00 (YR1) $0.00 (YR2) $0.00 (YR3) 3. Generic Discount: AWP minus 88.50% (YR1) 88.65% (YR2) 88.80% (YR3) 4. Generic Dispensing Fee: $0.00 (YR1) $0.00 (YR2) $0.00 (YR3) **SPECIALTY PHARMACY OPTIONS** **SPECIALTY PHARMACY** The guarantees for Specialty Pharmacy will be the following amounts: 1. Discount: AWP minus 22.00% (YR1) 22.00% (YR2) 22.00% (YR3) 2. Dispensing Fee: $0.00 (YR1) $0.00 (YR2) $0.00 (YR3)	**Measurement Period** Annual **Reporting Period** Annual

EMPLOYEE ASSISTANCE PROGRAM ("EAP")
SCHEDULE TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
City of Littleton

This EAP Schedule supplements and amends the Administrative Services Agreement ("Agreement") and is effective as of January 1, 2026 ("Effective Date"). If there are any inconsistencies between the provisions of this Schedule, any other Schedule, and/or the Agreement, the terms of this EAP Schedule shall control, but only as they relate to the EAP. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

A. DEFINITIONS. The following terms, when used in this EAP Schedule or any amendments hereof, are defined as follows:

1. **EAP Services** mean those services that an EAP Participant is entitled to receive as a result of or pursuant to this EAP Schedule and as described in the Services Overview.

2. **EAP Schedule or Schedule** means the contract entered into between Anthem and Employer under which Anthem provides EAP Services to EAP Participants. The EAP Schedule includes arrangements established by Anthem or by persons or entities utilizing the EAP Practitioner, pursuant to a contract with Anthem.

3. **EAP Practitioner** means, with regard to any health-related services provided under this Schedule, an appropriately licensed health care professional who has agreed to provide EAP Services for EAP Participants. In limited situations involving health-related services, EAP Practitioner can also include licensed health care professionals who are not participating in the applicable EAP network, but who have been approved by Anthem and have agreed to perform a one-time or set number of EAP Services for a particular EAP Participant. For non-health-related services provided under this Schedule, including, but not limited to, legal consultations, financial consultations, and concierge or convenience services, EAP Practitioner means an appropriately trained and/or licensed professional approved by and/or with an agreement with Anthem to provide a one-time or set number of EAP Services to an EAP Participant.

4. **EAP Participant(s)** means an Eligible Employee and any Eligible Household Members who are entitled to EAP Services under this Schedule and for whom Eligible Employee Fees are paid by Employer.

5. **Eligible Employee(s)** means Employer employees, retirees, and/or COBRA enrollees as determined by Employer.

6. **Eligible Household Member(s)** means the spouse, domestic partner, dependents, and others whose place of residence is the same as the Eligible Employee, and/or those dependents who do not share the same residence as the Eligible Employee but due to applicable state law or court order are required to be covered under this EAP Schedule.

B. ELIGIBLE EMPLOYEE FEE

1. Employer shall pay to Anthem a monthly fee ("Eligible Employee Fee") and any other charges to cover all EAP Participants. The amount of the Eligible Employee Fee and payment specifications under this EAP Schedule are set forth in Schedule A of the Agreement. Employer will reimburse Anthem for any mutually agreed upon travel costs.

2. Employer will pay all Eligible Employee Fees unless other provisions for payment are agreed to in advance by Anthem.

3. If a state or any other taxing authority imposes a tax on Anthem that is based on the Eligible Employee Fee, the Eligible Employee Fee stated in this EAP Schedule will be increased by an amount sufficient to cover that tax. This increase will begin on the date the tax goes into effect. Any subsequent change to the tax may result in a further increase in Eligible Employee Fee.

C. ADMINISTRATION

1. Anthem and Employer agree that Anthem or its designee shall provide EAP Services to EAP Participants under this EAP Schedule as set forth in the Services Overview.

2. EAP Services do not include assessment or treatment by a psychiatrist.

3. Anthem may assist EAP Participants to obtain necessary and appropriate levels of care in the community or through the EAP Participant's health plan.

4. All EAP Services must be obtained by contacting Anthem directly for a referral for EAP Services to an EAP Practitioner. EAP Services for unauthorized treatment or services obtained from non-EAP Practitioners are not reimbursable. Anthem maintains an online EAP Practitioner directory and a 24 hour toll-free or local telephone number to find an EAP Practitioner. In non-emergency situations, EAP Participants are provided names of EAP Practitioners or other resources. When the EAP Participant contacts Anthem to obtain non-emergency EAP Services, Anthem will conduct a telephone assessment. The telephone assessor will make a good faith effort to: provide crisis intervention over the telephone; arrange an appointment with an EAP Practitioner, or if an EAP Practitioner is not reasonably available or accessible, provide access to a licensed mental health professional in the EAP Participant's area and/or provide names of licensed mental health professionals in the area; or direct the EAP Participant in obtaining more intensive, acute care services. EAP Services are not intended to be emergency services. Any EAP Participant calling for an emergency or urgent situation will be immediately referred to a licensed mental health professional or an appropriate facility.

D. ELIGIBILITY

1. EAP Participants who are eligible on the day this EAP Schedule begins will be able to obtain EAP Services on the EAP Schedule Effective Date. The ability to obtain EAP Services under this EAP Schedule will terminate at 11:59 P.M. on the last day of an EAP Participant's eligibility or termination of this Schedule, whichever occurs first.

2. Employer shall provide a count of all Eligible Employees upon implementation of this EAP Schedule. Employer shall inform Anthem when the count varies by 10% from any previous report.

3. Only EAP Participants are eligible for services under this EAP Schedule.

4. Employer shall be responsible for determining Eligible Employees. Any disputes or inquiries regarding eligibility (including renewal and reinstatement) shall be referred by Anthem to Employer, which shall advise Anthem of its determination.

5. Unless otherwise agreed upon by the Parties, eligibility under this EAP Schedule shall be limited to residents of the United States, including any U.S. Territories.

6. Anthem shall have the sole right to terminate eligibility of any EAP Participant who uses threatening or aggressive behavior.

E. POST TERMINATION SERVICES. In the event of termination of this EAP Schedule, Anthem agrees that EAP Practitioner will complete the provision of EAP Services that were, in Anthem's reasonable opinion, being delivered prior to such termination and continuity of care warrants completion of such services subject to applicable EAP Services covered by this Schedule ("Post Termination Services"). In the event Anthem provides Post Termination Services, both Parties agree that those Post Termination Services shall be provided and reimbursed by Employer in accordance with the terms of this Schedule.

F. COMPLAINTS AND GRIEVANCES. Anthem agrees to investigate and resolve any complaints or grievances received from EAP Participants with regards to EAP Services.

G. PROFESSIONAL-PATIENT RELATIONSHIP

1. Anthem will make every reasonable effort to arrange for EAP services as herein provided in accordance with the prevailing national and regional professional standards.

2. Employer understands and acknowledges that the relationship between the EAP Participant and EAP Practitioners and other participating professionals shall be subject to the rules, limitations, and privileges incident to any professional relationship, including, but not limited to, the doctor-patient or therapist-patient relationship. Anthem shall be solely responsible, without interference from Employer or any of its agents, to the EAP Participant for arranging EAP Services, subject to Section G(3) below.

3. Employer understands and acknowledges that the operation and maintenance of the EAP Practitioners' offices and the provision of all services shall be solely and exclusively under the control and supervision of the EAP Practitioner, including, but not limited to, all authority and control over the selection of staff, supervision of personnel and operation of the professional practice, and/or the provision of any particular professional service or treatment.

H. GENERAL PROVISIONS

1. Employer understands and acknowledges that this EAP Schedule provides EAP Services only, is not an insurance policy, and does not indemnify nor reimburse any EAP Participant or Employer for the cost of health care services.

2. Anthem will furnish promotional materials to Employer as mutually agreed upon. Employer shall distribute only approved EAP materials to EAP Participants.

3. Anthem shall maintain an EAP Practitioner network to provide EAP Services to Employer. Subject to applicable state or federal law and regulation, Anthem shall have final authority to interpret its contracts with Providers, and Employer agrees that (a) it is not a Party to Anthem's contracts with Providers and (b) it will accept Anthem's interpretations of said contracts. Furthermore, Anthem shall have full authority and discretion to resolve any questions or disputes with Providers that participate in any of Anthem's Provider networks, except as applicable law provides for judicial or regulatory review of such disputes, and Employer will accept said resolution of such matters as final.

4. In the event that Anthem fails to pay the EAP Practitioner for costs of EAP Services, the EAP Participant shall not be liable to the EAP Practitioner for any sums owed. Anthem does not pay non-EAP Practitioners nor reimburse EAP Participants for any sums they may pay directly to any EAP Practitioner for services rendered.

5. Anthem acknowledges that it is a Covered Entity (as defined in 45 CFR 160.103) for purposes of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") when providing the EAP Services. Anthem represents and warrants that for as long as Anthem creates, receives, maintains or transmits the protected health information ("PHI") (as defined in 45 CFR 160.103) of EAP Participants, Anthem will comply with HIPAA, the Health Information Technology for Economic and Clinical Health ("HITECH") Act and their implementing regulations with respect to EAP Participants' PHI. In addition, it is understood and agreed that for purposes of maintaining EAP Participant privacy, Provider-patient confidentiality, and Anthem's duties and responsibilities as the Covered Entity in connection with the requirements imposed by HIPAA and the privacy and security regulations promulgated thereunder, all records relating to services provided under this Schedule shall be confidential property of Anthem and can only be disclosed to Employer upon written release by EAP Participant or otherwise required by law.

6. Each Party shall be responsible for complying with all applicable laws and regulations. In the event Employer is regulated under the Employee Retirement Income Security Act of 1974 ("ERISA"), Employer covenants and agrees that it and not Anthem shall be responsible for meeting all requirements of ERISA. Anthem will cooperate with Employer in supplying Employer with information within its possession to aid Employer in meeting any ERISA reporting requirements.

NON-NEGOTIABLE – THIS SCHEDULE REPRESENTS ANTHEM'S BUSINESS PROCESSES

INFORMATION SECURITY SCHEDULE
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
City of Littleton

This Information Security Schedule supplements and amends the Administrative Services Agreement and is effective as of January 1, 2026. In the event of an inconsistency between the applicable provisions of this Schedule, any other Schedule and/or the Agreement, the terms of this Schedule shall govern, but only as they relate to information security. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

1. Definitions.The definitions noted below shall apply for purposes of this Information Security Schedule.

    a. "Covered Information" means Protected Health Information, as defined under the Parties' Business Associate Agreement (BAA) and Personal Information, as defined under applicable state data breach notification laws.

    b. "Information System" means an interconnected set of information resources and includes hardware, software, databases, and applications that collect, process, store, transmit, display, disseminate, and act on Covered Information.

2. Written Information Security Program. Anthem represents that it has established, and shall maintain for the duration of this Agreement, a written information security program that addresses the management of security and the controls employed within the organization to protect the confidentiality, integrity, and availability of Covered Information.

3. Security Policy and Procedures. Anthem shall maintain policy and procedures relating to the safeguarding of data relevant to Covered Information. Anthem shall undertake reasonable efforts to maintain this program in accordance with reasonable industry practices and guidelines from HITRUST (or other similar industry body) that are designed to protect against accidental or unlawful destruction, loss, alteration, or unauthorized third-party disclosure or access to Covered Information.

4. Use of Administrative, Physical and Technical Safeguards.The written information security program and security policy and procedures are designed to clearly identify those technical and organizational measures and practices to be implemented and followed by Anthem, including appropriate administrative, physical, and technical safeguards, which are intended to reasonably protect the security of Covered Information processed by Anthem.

5. Evaluation of Written Information Security Program and Security Policy and Procedures.Anthem agrees that it will take reasonable efforts to review and, as needed, update its written information security program and security policy and procedures at reasonable intervals and whenever there are material changes to Anthem's relevant Information Systems. The Parties affirmatively recognize, however, that both information security best practices and threats to the security of Covered Information are ever evolving and therefore nothing in this Schedule should be interpreted as a contractual promise by Anthem to guarantee perfection in protecting Covered Information or in meeting all information security best practices.

6. Use of Information Classification Standards.In its performance under this Agreement, Anthem shall utilize information classification standards for classifying, labeling and handling of Covered Information.

7. Incident Response Program.Anthem will maintain a written program plan to detect and respond to security incidents. The program will include identification, containment, mitigation, and remediation of an incident. Notification of Security Incidents, as defined under the Parties' BAA, or as may be required under applicable state data breach notification laws, shall be handled in a manner consistent with the Parties' BAA.

8. Disaster Recovery and Business Continuity and Emergency Management.Anthem will maintain appropriate business continuity, disaster recovery and emergency management plans designed to enable Anthem to respond to and recover from material business process disruptions in a manner that will provide for the delivery of critical services under this Agreement in timeframes that align with Anthem's established recovery time objectives. Anthem shall test its business continuity, disaster recovery and emergency management plans at least annually.

9. Training and Awareness.After hire and periodically thereafter, Anthem shall conduct information security awareness training for Anthem personnel. Anthem's security policy and procedures shall periodically be published and communicated as relevant to Anthem personnel directly or indirectly involved in the processing or safeguarding of Covered Information.

10. Information Security Program Review.Anthem will engage in periodic security assessments, audits, and/or evaluations of its security program as it relates to the protection of Covered Information. Consistent with Anthem's written information security program, these activities include relevant third party evaluation of Anthem's security program, such as HITRUST CSF assessment and certification. Such reviews also include periodic internal and authorized third party network testing, such as vulnerability scans and penetration tests.

11. Access to Summarized Policies.Anthem shall, upon advance reasonable request that does not exceed once per year, provide Employer with reasonable and timely access to summarized policies, as permitted by Anthem's written information security program.